



INSTRUCTIONS

within 24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician or completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9954 CERTIFICATE OF DEATH

09907

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore County	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN Kensington	
TOWN Mt. Wilson		6 mo 29 days		STREET ADDRESS 3403 University Blvd West		(If rural give location) 1536-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital							
3. NAME OF DECEASED (First) Elizabeth (Middle) Northcutt (Last) Adams				4. DATE OF DEATH 9 26 1960			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 9/9/1900	9. AGE last birthday 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) S. Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME H. W. Northcutt				14. MOTHER'S MAIDEN NAME Sally Outlaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 237-18-0547			
17. INFORMANT & ADDRESS Hospital Records Mt. Wilson State Hospital				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 400.1 Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Severe generalized Arteriosclerosis over 5 yrs							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary TB, inactive. Diabetes mellitus							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) White Plains (State) New York			
21d. TIME OF INJURY (Month) Sept (Day) 26 (Year) 1960 (Hour) 14		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-24-60 , to 9-26-60 , that I last saw the deceased alive on 9-26-60 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. SIGNATURE Wm. Newcomer M.D. SUPERINTENDENT, Mt. Wilson, Md. DATE SIGNED 9-27-1960							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Bury Transit		DATE THEREOF 9/28/60		NAME OF CEMETERY OR CREMATORIUM Holly Springs		LOCATION (City, town, or county) Holly Springs, N. Carolina (State) N.C.	
24. REC'D BY REGISTRAR Reg. Dist. No. 32		REGISTRAR'S SIGNATURE Arthur S. Turner		25. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 131 E. Montgomery Ave., Rockville, Md.	
DATE SEP 29 '60							

19. *Leucosia* *leucostoma* *Leucosia* *leucostoma*

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THE JOURNAL OF CLIMATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

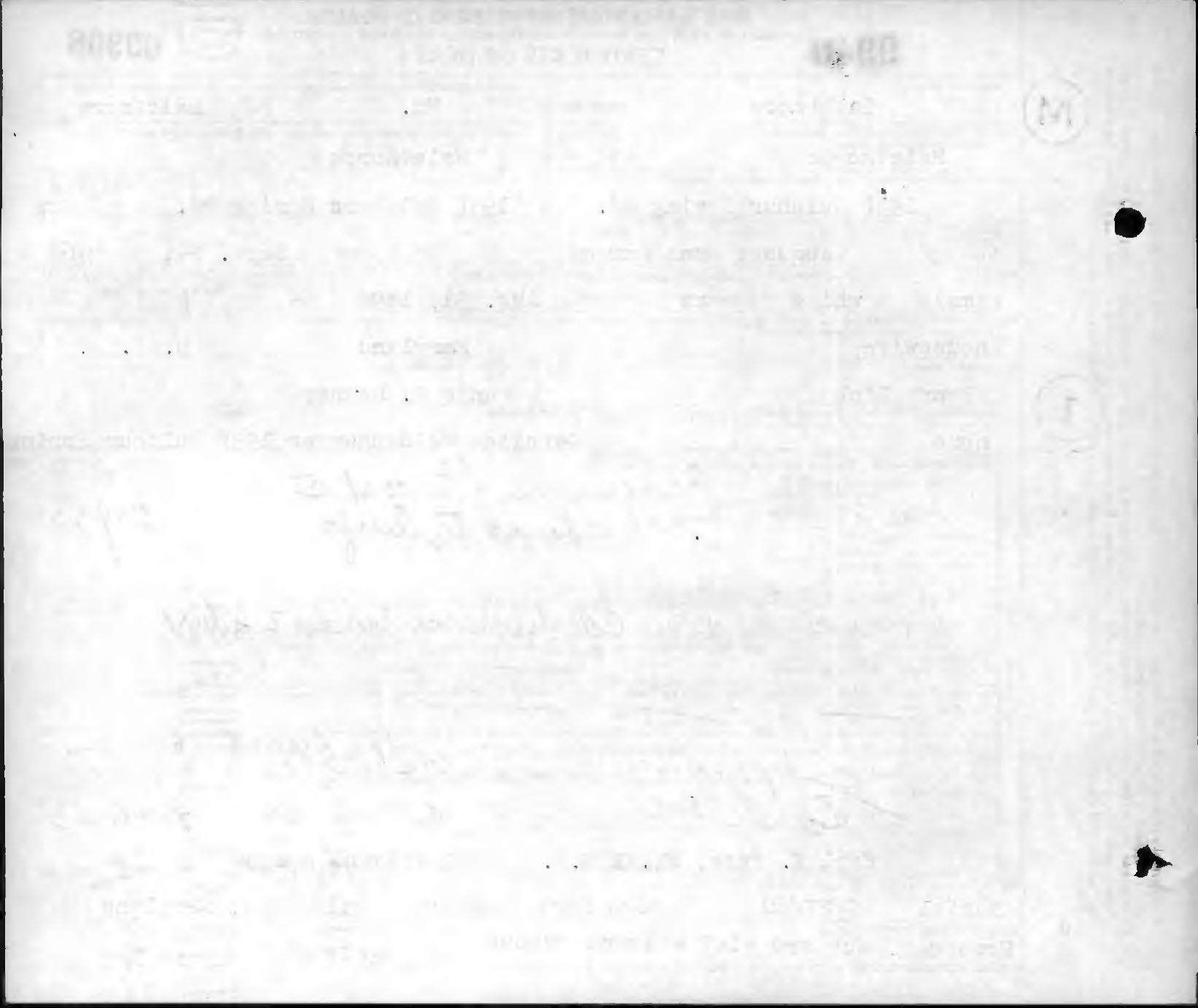
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9940

CERTIFICATE OF DEATH

09908

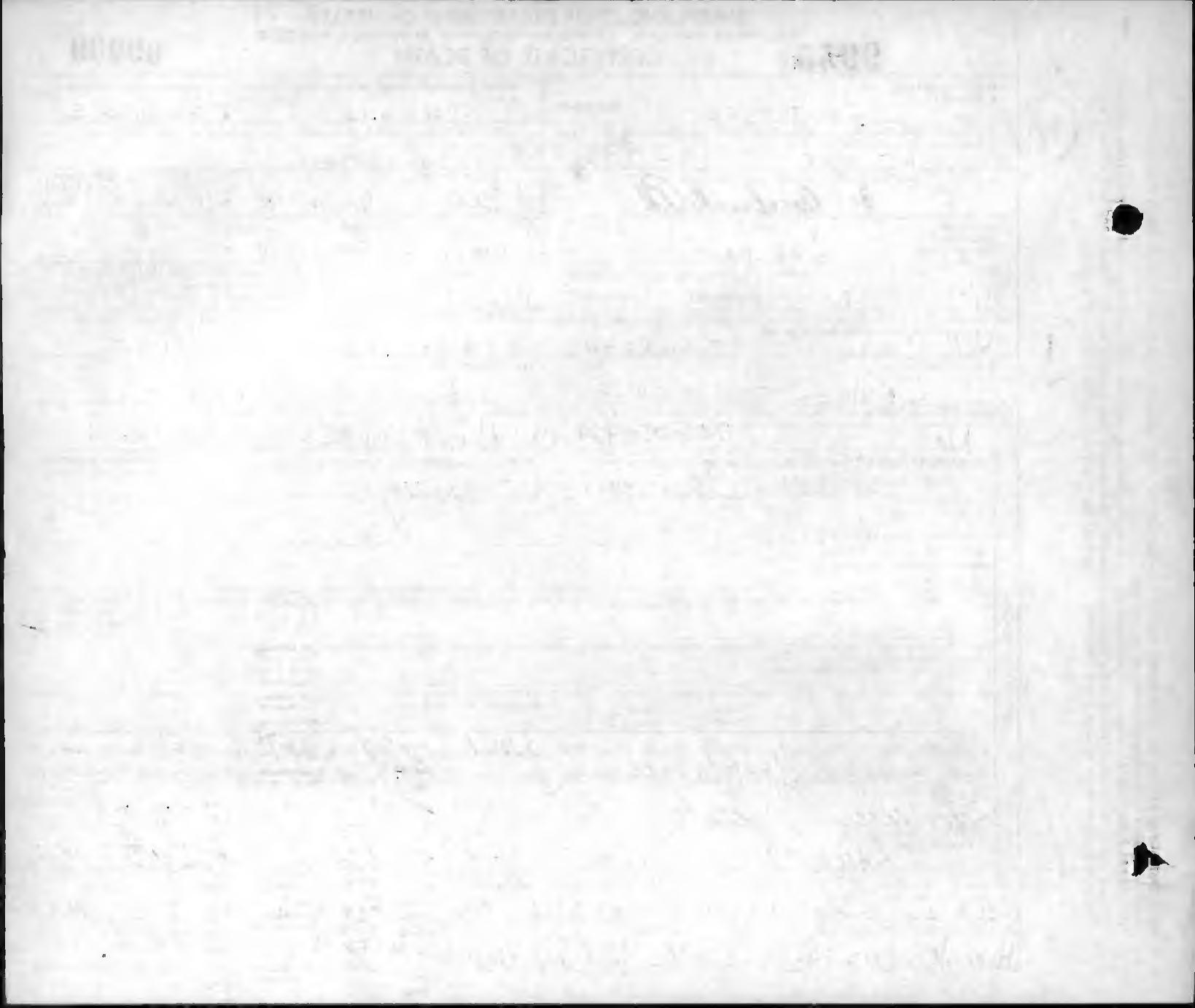
1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		Baltimore					
Halethorpe				51 Halethorpe							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1932 Sulphur Spring Rd.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Augusta Edna Ammond					Sept. 24,	1960					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 31, 1896							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
housewife					Maryland			U. S. A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Henry Link			Annie C. Benner								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
none					Caroline Weidenhammer		1932 Sulphur Spring				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
150X DUE TO Carcassoma of Breast c- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastases to lungs. (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH Rd											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arterios clerotic cardio Vasculasdes c failure											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from Sept 24 to Sept 26, 1960 that (I) (we) last saw the deceased alive on Sept 24, 1960, and that death occurred at 1 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Earl I. Pass</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 9-26-60	
22c. PHYSICIAN'S NAME (Type) Earl I. Pass, M.D.					22d. ADDRESS 4001 Wilkens Avenue						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/60		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION (City, town, or county) Baltimore, Maryland			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE SEP 28 '60			25b. REGISTRAR'S SIGNATURE <i>Calley & Hunt</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN lb 12 YRS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Overbrook Rd.				d. STREET ADDRESS 301 OVERBROOK ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First C	Middle H	Last CHRISTIAN	4. DATE OF DEATH ARCHIBALD		Month SEPT	Day 16	Year 1960				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 25 1900		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. CLERK				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SAMUEL ARCHIBALD				14. MOTHER'S MAIDEN NAME LOUISE REMMERS								Address Mrs Alma Archibald 301 Overbrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1960 to Sept 16 1960 , that (I) (we) last saw the deceased alive on Sept 16 1960 , and that death occurred at 4 AM , from the causes and on the date stated above.													
22a. SIGNATURE Laurence C. Post													
22b. DATE SIGNED 9-16-60													
22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 6805 York Rd; Balt., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF SEPT 19, 1960			23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEM			23d. LOCATION (City, town, or county) (State) ANNAPOLIS, MARYLAND				
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO. 4905 YORK RD, BALTO			ADDRESS			25a. REC'D BY REGISTRAR DATE SEP 19 '60			25b. REGISTRAR'S SIGNATURE Charles S. Krause				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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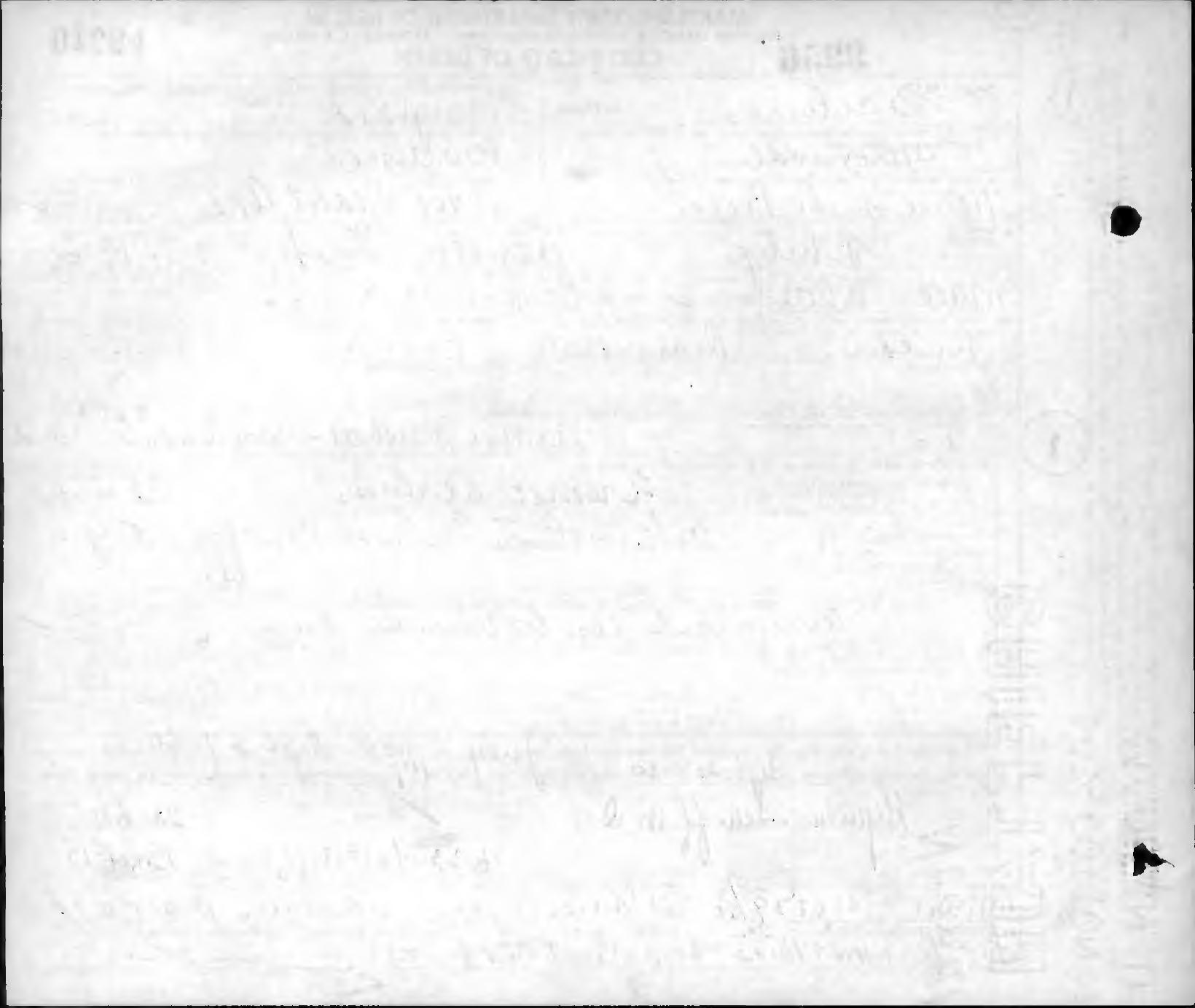
9956

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eatonsville		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House on the Pines			d. STREET ADDRESS 2901 Walk Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Philip		First P	Middle A	Last Philip	4. DATE OF DEATH Sept 27, 1960
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Samuel J. Ashell - 4306 Garrison Blvd apt D
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 442			INTERVAL BETWEEN ONSET AND DEATH 2 weeks.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Arteriosclerotic Cardio Vasc. Neural Disease			DUE TO (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Cerebrovascular Disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1954 to Sept 27 1960 , that (I) (we) last saw the deceased alive on Sept 25 1960 , and that death occurred at 11 PM , from the causes and on the date stated above.					
22a. SIGNATURE Hyman Schiff M.D.					
22b. DATE SIGNED 9-28-60					
22c. PHYSICIAN'S NAME (Type)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 29 1960		23c. NAME OF CEMETERY OR CREMATORIAL Straight Zion	
24. FUNERAL DIRECTOR'S SIGNATURE Sal Lennon & Sons - 6010 Reist Road		23d. LOCATION (City, town, or county) Rosedale, Maryland		(State)	
24e. ADDRESS Sal Lennon & Sons - 6010 Reist Road		25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Lewis	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 year monthly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Elsie Marie		First (Banglesdorf)	Middle
4. DATE OF DEATH September 11 1960		Last Banglesdorf	Month September
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 8, 1896		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Brush Factory	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Louis Daubert	
14. MOTHER'S MAIDEN NAME Emma		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 220-14-6066		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154.3		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Congestive heart failure	
DUE TO Cor pulmonale (c)		Persistant ostium secundum	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 26 1956 to Sept. 11, 1960 , that (I) (we) last saw the deceased alive on Sept. 11 1960 , and that death occurred at p. M. , from the causes and on the date stated above.		22b. DATE SIGNED 9-12-60	
22a. SIGNATURE Stella Wachsler		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/1960	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Cemetery
23d. LOCATION (City, town, or county) Woodlawn		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.	25a. REC'D BY REGISTRAR DATE SEP 13 '60
			25b. REGISTRAR'S SIGNATURE Chilton S. Kraus

1100

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09912 ✓

9958

1. PLACE OF DEATH a. COUNTY BALTO 28		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATSBYVILLE		b. COUNTY PRINCE GEORGE CO	
c. LENGTH OF STAY IN 1b 7 - 1965		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTLINE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS MAPLE AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JENNIE	Middle -	Last BELL
4. DATE OF DEATH	Month Sep	Day 27	Year 1965
5. SEX F	6. COLOR OR RACE BL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1873
9. AGE (in years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) NEW YORK	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ira Thompson	14. MOTHER'S MAIDEN NAME Elsie Christiana		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 111-11-1111	17. INFORMANT Mr. HOWARD FIELD	Address MAPLE AVE BELTSVILLE MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
CARDIOVASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 11, 1965 to SEPT. 24, 1965 , that (I) (we) last saw the deceased alive on SEPT. 24, 1965 , and that death occurred after 12 M, from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Arizaga		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA		22d. ADDRESS SPRING GROVE STATE HOSPITAL	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Removal - Burial		23b. DATE THEREOF 9/28/60	
23c. NAME OF CEMETERY OR Crematorium Rosendale Plains		23d. LOCATION (City, town, or county) (State) Rosendale N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR DATE SEP 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knudsen	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

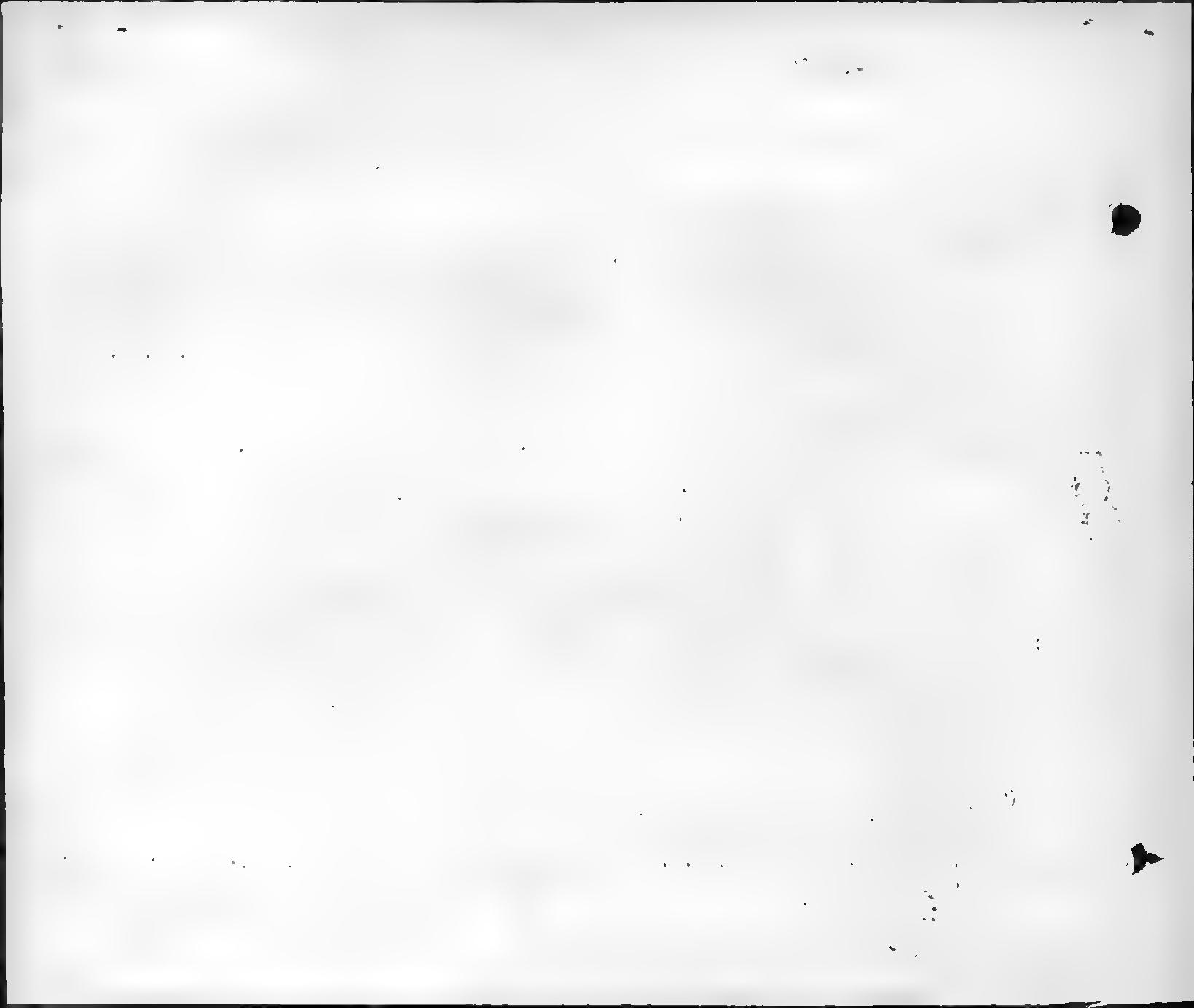
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9959

CERTIFICATE OF DEATH

09913

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 20 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS ██████████		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First PERCY	Middle M.	Last BELL	4. DATE OF DEATH	Month September	Day 20	Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1897	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Percy Bell		14. MOTHER'S MAIDEN NAME Florence Hall						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WW I		16. SOCIAL SECURITY NO. 220-03-522		17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. FT. HOWARD DIVISION		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH 0 HOURS	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 465		MASSIVE PULMONARY EMBOLISM WITH PULMONARY INFARCTS						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		ACUTE HEMORRHAGIC PANCREATITIS					20 DAYS	
(b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (s) (this hospital) attended the deceased from August 31, 1960 , to Sept. 20, 1960 , that (s) (we) last saw the deceased alive on Sept. 20, 1960 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.								
22a. SIGNATURE 		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 9/21/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 25, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Carroll's Church Cemetery		23d. LOCATION (City, town, or county) Calvert County, Maryland		(State)
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Huntingtown, Maryland		25a. REC'D BY REGISTRAR SEP 26 1960		25b. REGISTRAR'S SIGNATURE Charles S. Thomas		
LeRoy Berry				DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

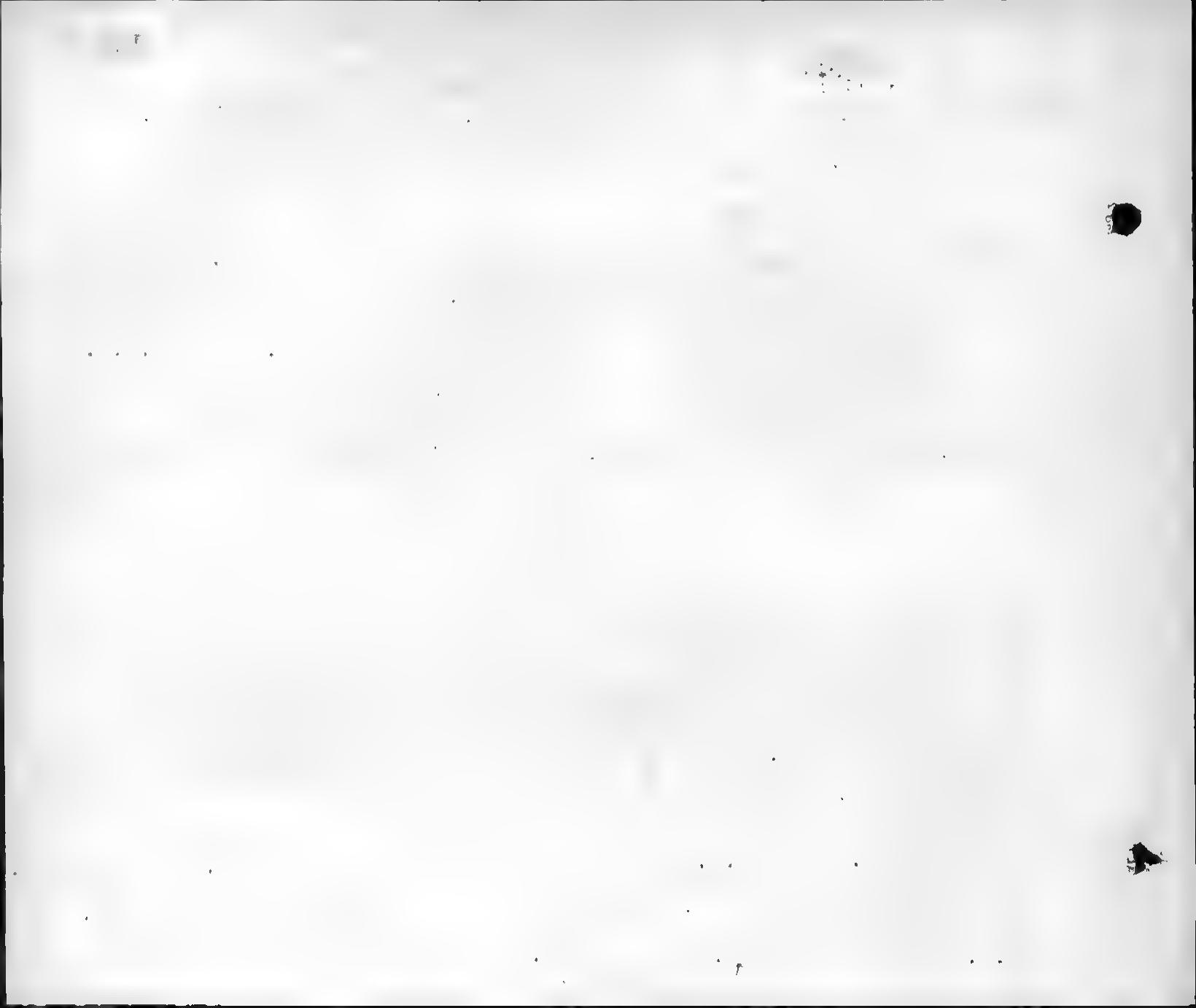
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09914

1 M		9960		2 Balto.	
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b		b. COUNTY Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 605 Upland Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
3. NAME OF DECEASED (Type or print) Sara		First S	Middle Shreve	4. DATE OF DEATH Sept. 25 1960	Month Day Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1878	9. AGE (In years last birthday) 82 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
13. FATHER'S NAME James Madison Wallace		14. MOTHER'S MAIDEN NAME Sara Matilda Shreve		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-2448B		17. INFORMANT Miss Matilda Bishop	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Arterio - sclerosis & hypertension		2 years.	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 1960 to Sept 25 1960 , that (I) (we) last saw the deceased alive on Sept 25 1960 , and that death occurred at 77 M , from the causes and on the date stated above.		22b. DATE SIGNED			
22a. SIGNATURE Palmer F.C. Williams		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Dr. Palmer F.C. Williams		22d. ADDRESS 1725 Reisterstown Rd., Pikesville Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-27-60		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd., Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

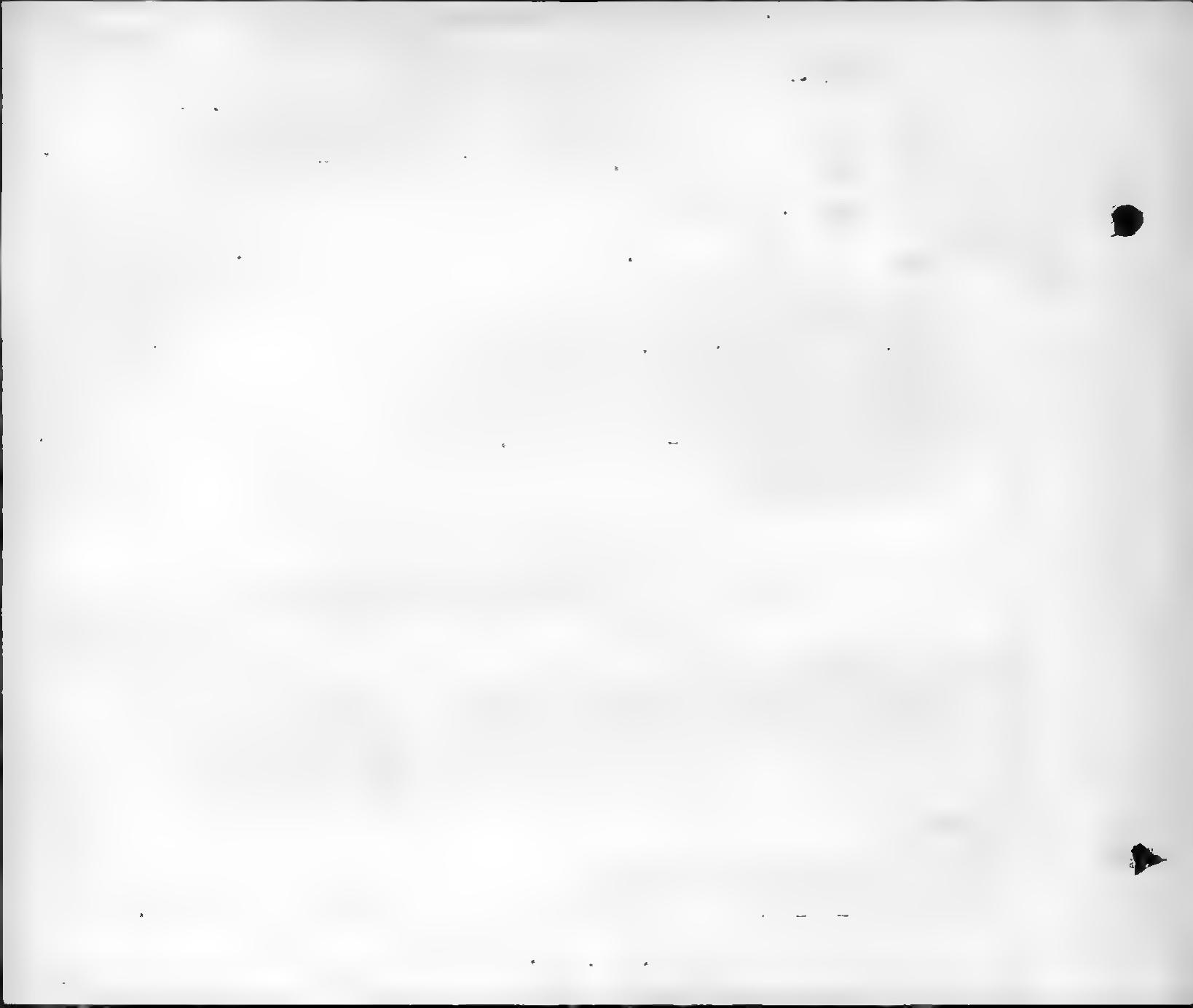
9961

CERTIFICATE OF DEATH

9916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 914 D Street, Sparrows Point		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Farm- Edgemere	
3. NAME OF DECEASED (Type or print) Franklin T. Blevins		d. STREET ADDRESS 17413 Blevins Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Sept. Day 7 Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1927	
9. AGE (In years lost birthday) yrs 33		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Pataps. Bk Rvr RR Maryland	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Blevins		14. MOTHER'S MAIDEN NAME Bessie Mae Ashley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. Army WW II 212-20-4249	
17. INFORMANT		Address Mrs. Regina Blevins 7413 Blevins Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Acute myocardial infarction 2 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 7, 1960</u> , to <u>Sept 7, 1960</u> , that I last saw the deceased alive on <u>Sept 7, 1960</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>914 D St., Balt</u> DATE SIGNED <u>19, 2nd 9-7-60</u>	
ACTUAL SIGNATURE <u>John V. Conway</u>		PHYSICIAN'S NAME (Type) <u>John V. Conway</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
		24b. REGISTRAR'S SIGNATURE <u>Orville S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09917

Reg. Dist. No.

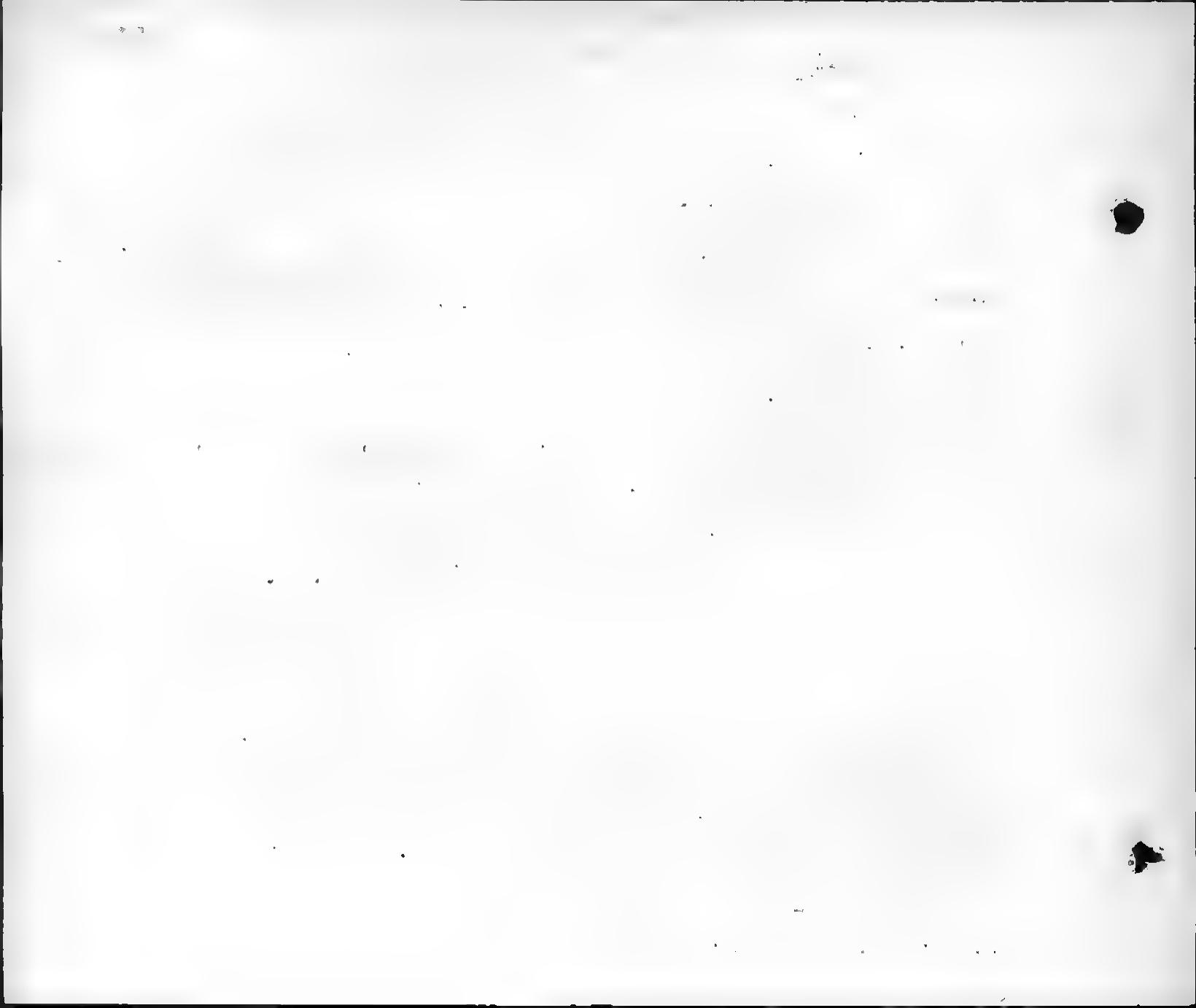
9962

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY <i>R. A. C.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore 12				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home Smithwood & Summit Ave		d. STREET ADDRESS 6317 Banbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH BODE	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1871		9. AGE (In years (last birthday) yrs 89	10. IF UNDER 1 YEAR / IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Wilhelm H. Bode		14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT C. Allen Hechter, 6 Club Road, Baltimore 10		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac. Pulmonary Edema</i> DUE TO <i>Coronary Insuf.</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Arterioscl. cardiovascular Disease</i> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1709 Edmonson ave		(County) (State)
21. I certify that I attended the deceased from <i>Sept 29, 1960</i> , to <i>Sept 29, 1960</i> , that I last saw the deceased alive on <i>Sept 29, 1960</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Catonsville								
DATE SIGNED <i>1709 Edmonson ave</i>								
ACTUAL SIGNATURE <i>J. KUDIRKA</i>		PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-1-60		22c. NAME OF CEMETERY OR CREMATORIUM Govans Presbyterian		22d. LOCATION (City, town, or county) Baltimore 12, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it may be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09918

CERTIFICATE OF DEATH

Reg. Dist. No.

9963

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b SYRlumthllyds				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Harrison	Middle T.	Last Bostwick			
4. DATE OF DEATH	Month September	Day 10	Year 1960			
5. SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 28, 1906	9 AGE (In years lost birthday) 54 yrs.	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Harrison Bostwick		14. MOTHER'S MAIDEN NAME Louisa C. Wistland		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO 217-05-3405		17. INFORMANT Mrs. Ida Bauer, 2006 East Federal Street		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		Chronic bronchitis and tongue metastasis to the hypopharynx		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome due to syphilis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ June 3, 1959, to Sept. 10, 1960, that I last saw the deceased alive on Sept. 10, 1960, and that death occurred at 8 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Loretta Y. F. Hsu M.D.				ADDRESS (Street, city or town, state) DATE SIGNED		
PHYSICIAN'S NAME (Type) LORETTA Y. F. HSU				SPRING GROVE STATE HOSPITAL		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Baltimore (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Charles L. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY
Balto.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rodgers Forge - Balto. 12

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

100 Dumbarton Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

o. STATE

Md.

b. COUNTY

Balto.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rodgers Forge - Balto. 12

d. STREET ADDRESS

100 Dumbarton Rd.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Sept. 11, 1960

Month Day Year

5. SEX

6. COLOR OR RACE

male

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 26, 1874

9. AGE (In years
lost birthday)

86 yrs

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Asst Harbor Master

10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jere L. Boyd

14. MOTHER'S MAIDEN NAME

Margaret Betz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

INFORMANT

Mrs. Margaret A. Boyd - 100 Dumbarton Rd.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Acute coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

5 min

10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

none

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
White Not white
 at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Aug 25, 1943 to Sept 11, 1960, that I last saw the deceased alive on Jan 25, 1960, and that death occurred at 9 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREA.S. Chalfant MD 6210 York Road
Dr. A. S. CHALFANT BALTIMORE, MD, my22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

9/14/60

22c. NAME OF CEMETERY OR CREMATORIUM

London Park Cem.

22d. LOCATION (City, town, or county)

Balto., Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Vukner & Sons - Balto.

ADDRESS

17 N

24a. REC'D BY REGISTRAR

Sep 13 '60

24b. REGISTRAR'S SIGNATURE

Clyburn S. Kraus



1

FOR STATE
HEALTH DEPT.

M

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a longer day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15921

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Baltimore</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Valley Rd.</i>		<i>3000 Maryland Avenue</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>HARRIETTE DORN</i>		<i>Harr</i>	<i>Riette</i>
4. DATE OF DEATH		Month	Day Year
<i>Sept. 24, 1960</i>		9	24 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Female</i>		<i>White</i>	<input checked="" type="checkbox"/>
8. ID. OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
<i>None</i>		<i>3</i> yrs.	11. CITIZEN OF WHAT COUNTRY?
12. FATHER'S NAME		<i>U.S.A.</i>	
13. MOTHER'S MAIDEN NAME		<i>Harratt S. Schubert</i>	
14. INFORMANT		Address	
<i>Stuart Buppert</i>		<i>3000 Maryland Avenue, Pikesville, Baltimore, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give rank or date of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>		<i>Stuart Buppert</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>6 hrs to 12 hrs</i>	
<i>929.</i>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g.,			
<i>None.</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
<i>None.</i>		<i>Fell over, struck head on floor.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>Sept. 24, 1960</i>		<i>Druid Ridge Cemetery, 3000 Maryland Ave., Baltimore, Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Z. D. Rodger</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>T. D. GARNERS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <i>9/27/60</i>		Address (Street, city, town, or county) <i>Pikesville, Md.</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Pikesville, Md.</i>	
23. FUNERAL DIRECTOR <i>John J. Vielner & Sons - Baltimore</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 27 '60</i>	
ADDRESS <i>1111 N. Charles Street</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9966

Item 2 Film 6712 14-00 et

11036

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel Co.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		d. STREET ADDRESS <i>Trailer Camp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Marion C. Burge</i>		First	Middle	Last	4. DATE OF DEATH Month <i>9</i>	Day <i>24</i>	Year <i>1960</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/7/1893</i>	9. AGE (in years last birthday) <i>67</i> yrs	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Sam? Cruse</i>		14. MOTHER'S MAIDEN NAME <i>?</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <i>Spring Grove Hosp. records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial Infarction, anterior-extensive</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arterio-sclerotic heart disease.</i>						INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO							
(c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>8-17-1960</i> , to <i>9-24-1960</i> , that (I) (we) last saw the deceased alive on <i>9-24-1960</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above							
22a. SIGNATURE <i>Stella Wachsler</i>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>9-27-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stella Wachsler, M. D.</i>		22d. ADDRESS <i>SPRING GROVE STATE HOSPITAL Catoctinville 28, Maryland</i>					
23a. BURIAL CREMATION REMOVAL, Specify <i>Burial</i>		23b. DATE THEREOF <i>10/6/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Matthew & Son Jr.</i>		ADDRESS <i>28</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 7 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

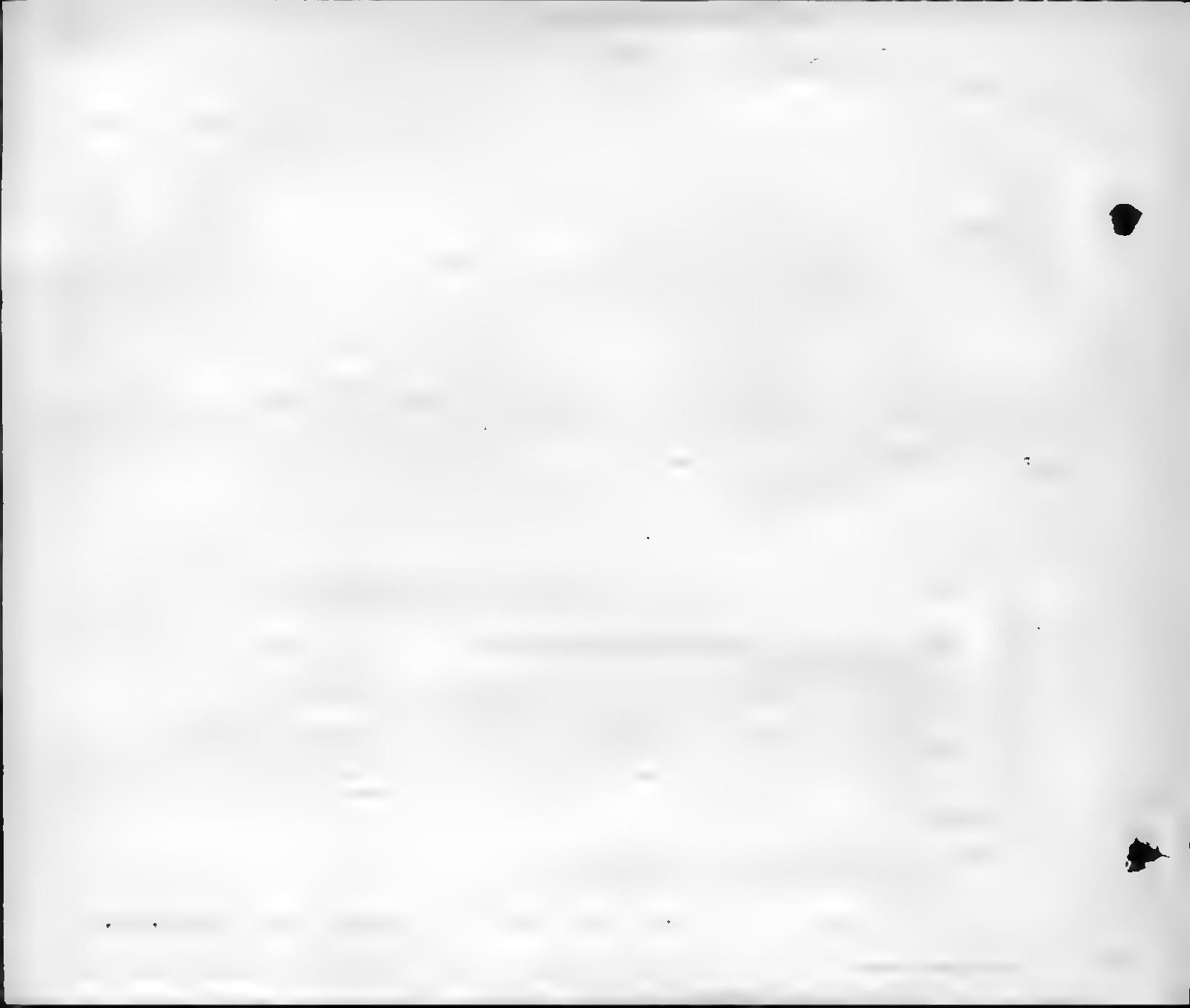
09922

9967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		c. LENGTH OF STAY IN b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sweet Air Road		d. STREET ADDRESS SWEET AIR ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle VIRGINIA	Last BURK	4. DATE OF DEATH September 25 1960	Month Year	Day	Year	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 2, 1887	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 4 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPINISTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY USA.		
13. FATHER'S NAME JOHN CONRAD BURK		14. MOTHER'S MAIDEN NAME LYNDE CHARLOTTE HOMAN		Address Glencor Gardens SPRINGFIELD				
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-34-1179		17. INFORMANT MRS EMMIE MOSNER PRICE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Occlusion Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month Sept	Day 25	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Maryland	(State) MD
21. I certify that I attended the deceased from 25 Sept 60 to 25 Sept 60 , that I last saw the deceased alive on 25 Sept 60 , and that death occurred at 11:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Walter J. Kees				DATE SIGNED Cecil S. Kees 25 Sept 60		
ACTUAL SIGNATURE Walter J. Kees	PHYSICIAN'S NAME (Type) Walter J. Kees	M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-28-1960	22c. NAME OF CEMETERY OR CREMATORIUM St. John's Lutheran	22d. LOCATION (City, town, or county) Sweet Air Balto Co. Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Jessie Lee Funeral Home 7401 Blair Rd.		ADDRESS Jessie Lee Funeral Home 7401 Blair Rd.	24a. REC'D BY REGISTRAR DATE SEP 27 '60	24b. REGISTRAR'S SIGNATURE Charles J. Kees				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09923

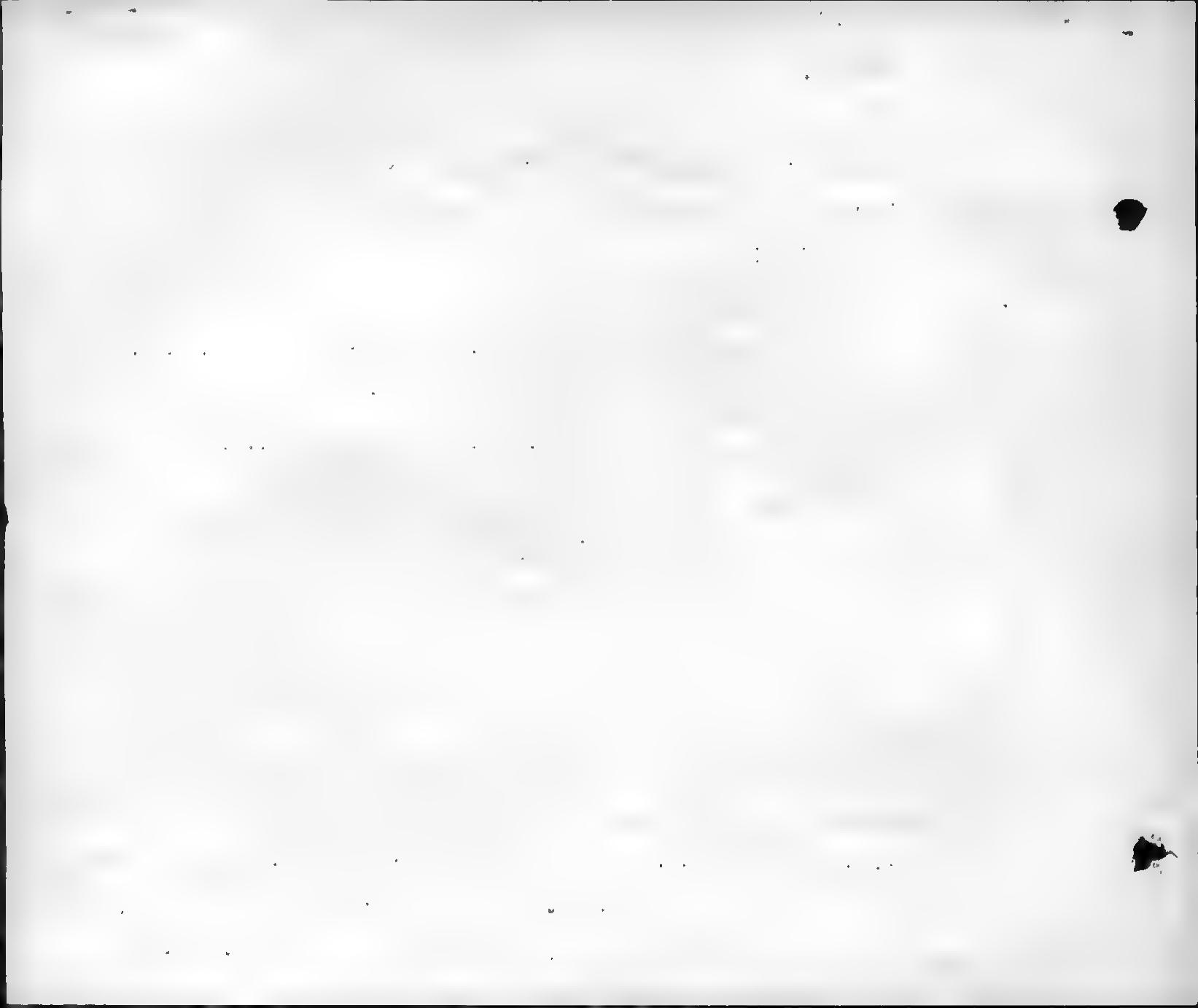
9968

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (5)		d. STREET ADDRESS 1210 Canal Court, Apartment B.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM		First WILLIAM	Middle --	Last BUTLER	4. DATE OF DEATH September 19 1960	Month September	Day 19	Year 1960	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 31, 1896	9. AGE (in years last birthday) 64 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	
8. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing Company		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Butler				14. MOTHER'S MAIDEN NAME Henrietta Johnson					
15. SOCIAL SECURITY NO. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FT. HOWARD DIVISION		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING CHRONIC PEPTIC ULCER OF STOMACH WITH MASSIVE HEMORRHAGE IN THE GASTRO-INTESTINAL TRACT INTERVAL BETWEEN ONSET AND DEATH 1 DAY Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MARKED CEREBRAL ARTERIOSCLEROSIS WITH OLD INFARCT OF THE RIGHT TEMPORAL OCCIPITAL LOBES 4 YEARS (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Maryland
21. I certify that (X) (this hospital) attended the deceased from Sept. 6 1960 to Sept. 19 1960 , that (X) (we) last saw the deceased alive on 9/19/60 19 11:45A M, from the causes and on the date stated above.									22b. DATE SIGNED 9/20/60
22a. SIGNATURE Frederick S. Donaldson		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/60		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.		23d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. 17		ADDRESS		25a. REC'D BY REGISTRAR SEP 22 '60		25b. REGISTRAR'S SIGNATURE Cynthia S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

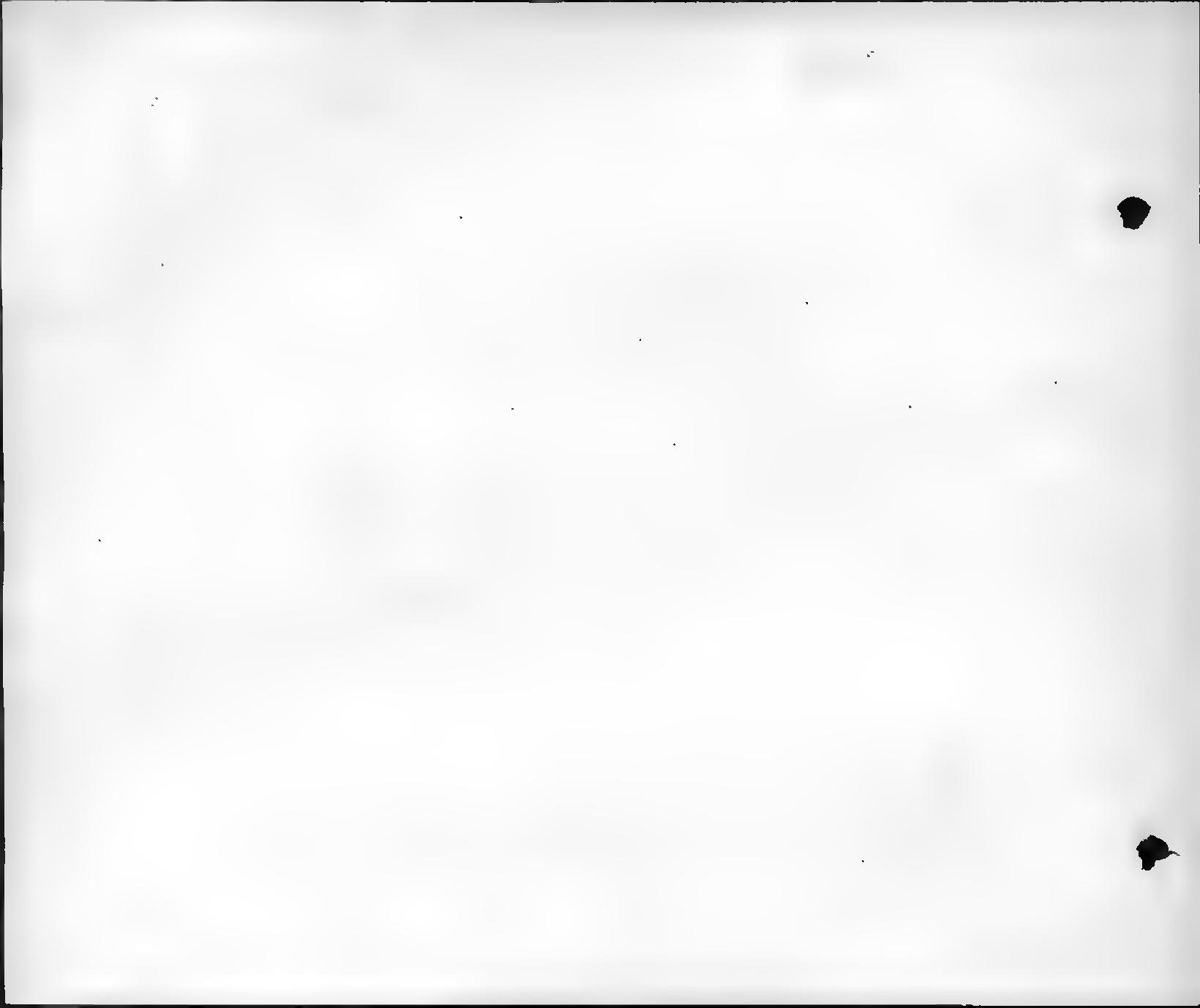
09924

Reg. Dist. No.

M

1. PLACE OF DEATH o COUNTY <i>Towson</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CENTER CIRCLE TOWSON ESTATES</i>		d. STREET ADDRESS <i>CENTER CIRCLE #1 TOWSON ESTATES</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>May-32-87 - M -</i>	Middle <i>Campbell</i>	Last Month Day Year 4. DATE OF DEATH <i>NOV-9-1873</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>NOV-9-1873</i>	9. AGE (In years last birthday) <i>86 yrs</i>
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BUYER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DEPT. STORE</i>	11. BIRTHPLACE (State or foreign country) <i>BALTIMORE - MD</i>
12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>GEORGE A. CAMPBELL</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET BARKER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>KATHERINE C. ROWNTREE</i>		Address <i>716 VALENCIA AVE CORAL GABLES, FLA</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <i>Central venous ulcer at incision site Infective hepatitis & cirrhosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>15 Aug 1960</i> to <i>15 Aug 1960</i> , that I last saw the deceased alive on <i>15 Aug 1960</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>John H. F. Campbell</i>		ADDRESS (Street, city or town, state) <i>1443 Hillside Dr., Ft. Lauderdale, FLA</i>	
DATE SIGNED <i>Aug 15 1960</i>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9-21-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>NEW CATHEDRAL</i>		22d. LOCATION (City, town, or county) <i>BALTIMORE - MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. M. Cook-Towson, Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 21 '60</i>	
ADDRESS <i>Towson 4-MD</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>	

TO HOSPITAL
may be attended by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09925

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for you.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation or removal.

M

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		e. STREET ADDRESS 1824 Park Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1824 Park Ave.						f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle H.	Last CAROTHERS	4. DATE OF DEATH	Month Sept.	Day 27,	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 3, 1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acct. Rtd.		10b. KIND OF BUSINESS OR INDUSTRY Singer Sewing Machine Co.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James F. Carothers				14. MOTHER'S MAIDEN NAME Clara Eisenberg				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sarah C. Phode - 13 Overbrook Rd.,		Address Catonville 28, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Hyperfunction Cardiac vascular disease</i> INTERVAL BETWEEN <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> (b) <i>Hyperfunction Cardiac vascular disease</i> (c) <i>Hyperfunction Cardiac vascular disease</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Danville	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John H. Kieffer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <i>Sept 28 1960</i>	
EXAMINER'S NAME (Type) <i>GEO S. KIEFFER M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9/30/60	22c. NAME OF CEMETERY OR CREMATORIUM Greenhill Cem.		22d. LOCATION (City, town, or county) Danville, Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Kieffer & Sons Funer</i>		ADDRESS <i>1824 Park Ave.</i>		24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE <i>John H. Kieffer</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

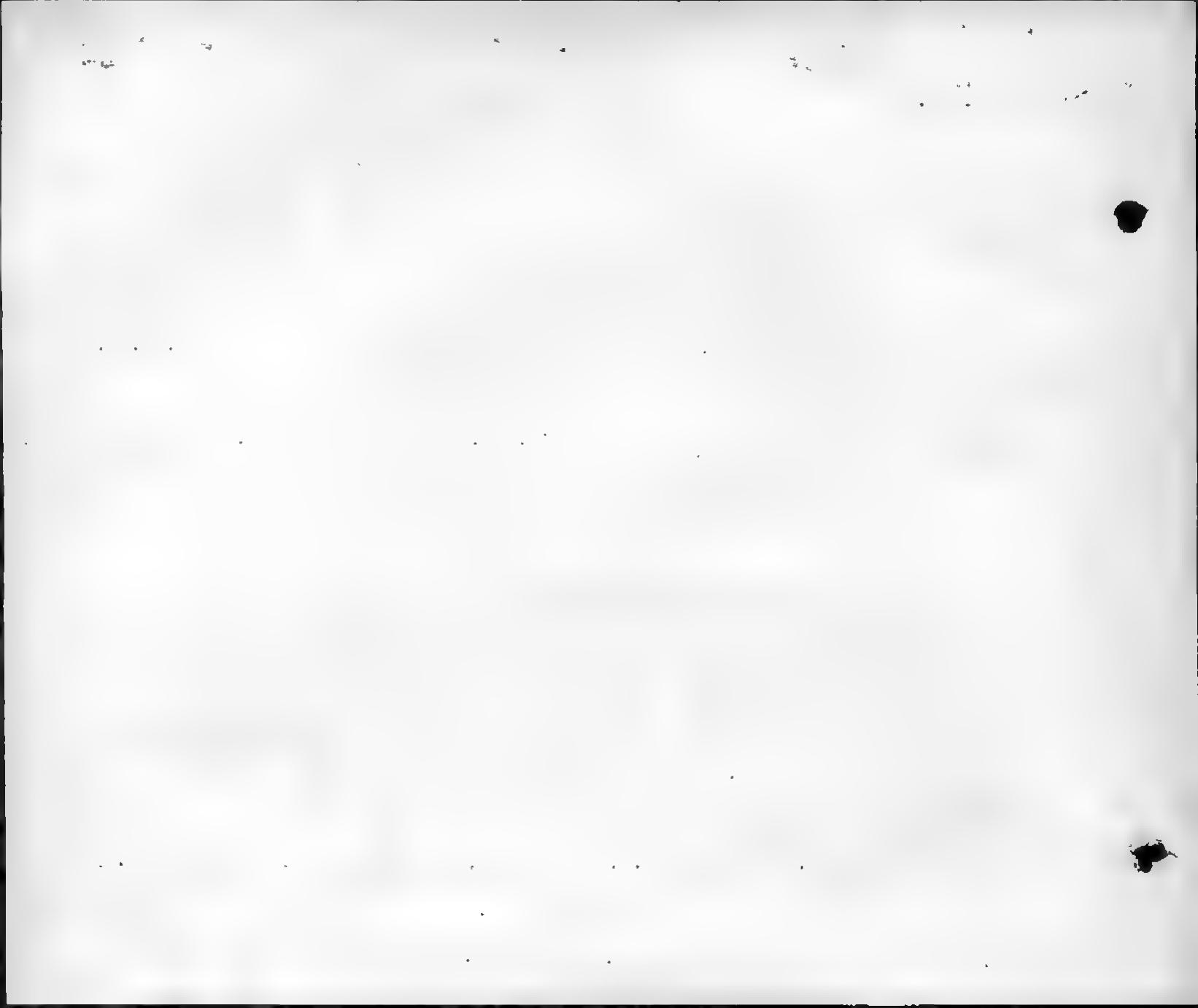
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

69926

9970

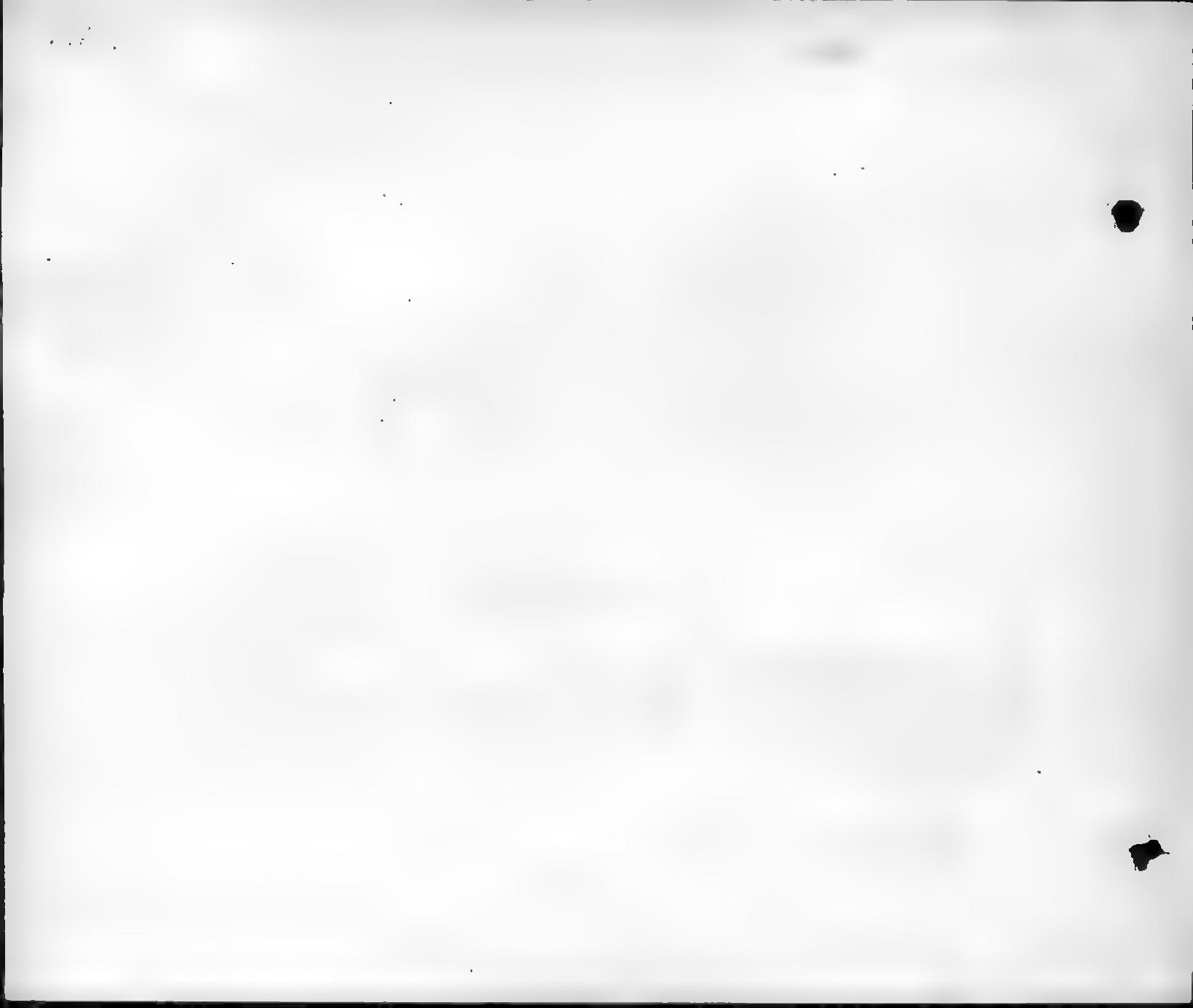
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 30 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (18)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 510 East Twenty-seventh Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PHILLIP	Middle ---	Last CARROLL	4. DATE OF DEATH September 1 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1894		9. AGE (in years at birthday) 66 yes	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Carroll		14. MOTHER'S MAIDEN NAME Ella MN: Henessey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO CARCINOMA OF SOFT PALATE							
INTERVAL BETWEEN ONSET AND DEATH 7 DAYS							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
4 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (He) attended the deceased from August 2 1960 to September 1 1960 , that (We) lost saw the deceased alive on Sept. 1 1960 , and that death occurred of P. M. from the causes and on the date stated above							
22a. SIGNATURE Fredrick S. Donaldson		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 9/2/60			
22c. PHYSICIAN'S NAME (Type) FREDRICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National.		23d. LOCATION (City, town or county) Baltimore (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Baltol 4, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										09927				
9971					CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u>					c. LENGTH OF STAY IN 16 <u>10 years</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Paul Ave.</u>					e. STREET ADDRESS <u>St Paul Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>GRACE</u>		First <u>Josephine</u>		Middle <u>CAVEY</u>		Last <u></u>		4. DATE OF DEATH <u>Sept. 18</u>		Month <u>Sept.</u>	Day <u>18</u>	Year <u>1960</u>		
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-18-1869</u>		9. AGE IN YEARS (last birthday) <u>91</u>		IF UNDER 1 YEAR IF UNDER 74 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houswife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry A. Bodkin</u>					14. MOTHER'S MAIDEN NAME <u>? Gallagher</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Mr. Francis Miller - Granite, Md.</u> Address <u></u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>171</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Carcinoma of Breast</u> DUE TO <u></u> (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)												
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>								
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1955, to <u>Sept. 18</u> , 1960, that (I) (we) last saw the deceased alive on <u>Sept. 18</u> , 1960, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above														
22a. SIGNATURE <u>Wm. E. Martin</u>					M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>					22d. ADDRESS <u>RANDALLSTOWN, MD.</u>									
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-60</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Alphonse</u>		23d. LOCATION (City, town, or county) <u>Woodstock, Bell Co., Md.</u>		(State) <u></u>						
24. FUNERAL DIRECTOR'S SIGNATURE <u>Father A. Height</u>		ADDRESS <u>Oxon Hill, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kuhn</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09928

9972

CERTIFICATE OF DEATH

1. PLACE OF DEATH o COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) WILLIAM		First H	Middle CHAMBERS
4. DATE OF DEATH SEPTEMBER 25 1960		Last CHAMBERS	Month Month
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-97
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY TAXI CAB COMPANY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CHAMBERS		14. MOTHER'S MAIDEN NAME LILLIAN DEYROFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) YES		16. SOCIAL SECURITY NO. 217-20-7798	
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X3000K		BILATERAL BRONCHOPNEUMONIA 1 WEEK	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first X3000K		(b) EDEMA OF LUNGS 1-1/2 DAYS	
		(c) EMPHYSEMA OF LUNGS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 22, 1960 , to Sept. 25, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 25, 1960 and that death occurred at 12:15 from the causes and on the date stated above.		22b. DATE SIGNED 9-25-60	
22c. PHYSICIAN'S NAME (Type) JEROME D. GORMAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS VAH Baltimore Md Ft. Howard Div
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-60	
23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		25a. REC'D BY REGISTRAR DATE SEP 27 '60	25b. REGISTRAR'S SIGNATURE Clifford S. Krause
ADDRESS 6009 Harford Rd Baltimore 14, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												109929
9973		CERTIFICATE OF DEATH										
		Item 1 filling 19-20-60 et										
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 220 Garden Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At his own home."												
3. NAME OF DECEASED (Type or print)		First Harry	Middle H.	Last Cheatham	4. DATE OF DEATH 9 14 1960	Month 9	Day 14	Year 1960				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1896	9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.	14. MOTHER'S MAIDEN NAME Unknown	Address 220 Garden Ridge Rd. 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Mfgr. Agt.		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.								
13. FATHER'S NAME Henry Cheatham		14. MOTHER'S MAIDEN NAME Unknown										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 186 09624		17. INFORMANT Rella M. Cheatham		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X		INTERVAL BETWEEN ONSET AND DEATH 1 week										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Bleeding Duodenal Ulcer										
		Carcinoma Pancreas - Liver Metastases 4 yrs Diabetes Mellitus 3 yrs										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 6-29-1956 to 9-14-1960 that (I) (we) last saw the deceased alive on 9-14-1960 and that death occurred at 8:40 PM , from the causes and on the date stated above.												
22a. SIGNATURE Robert Silver		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-16-60								
22c. PHYSICIAN'S NAME (Type) R. H. Silver		22d. ADDRESS 3105 N. Charles St. Baltimore, Md.										
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-1960		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City, town, or county) Baltimore		(State) Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE McGuff & Son		ADDRESS 28		25a. REC'D BY REGISTRAR DATE SEP 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hansen						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974

CERTIFICATE OF DEATH

05930

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Docksville (Rural)</i>	c. LENGTH OF STAY IN 1b <i>10 yrs</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	e. STREET ADDRESS <i>Docksville Rural</i>
d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) <i>ROSE - V - CHILCOAT</i>	First	Middle	Last	4. DATE OF DEATH <i>Sept 16 1960</i>
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5. SEX <i>W</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 25-1881</i>	9. AGE (in years last birthday) <i>79</i> yrs	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. Year Hours <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Huck</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
---	--	--	--

13. FATHER'S NAME <i>Charles T Harvey</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Brown</i>
--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	INFORMANT <i>Julian Johnson - Dover Rd - Upperco MD</i>	Address <i></i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153</i>		DUE TO <i>Chronic disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO (c) <i></i>

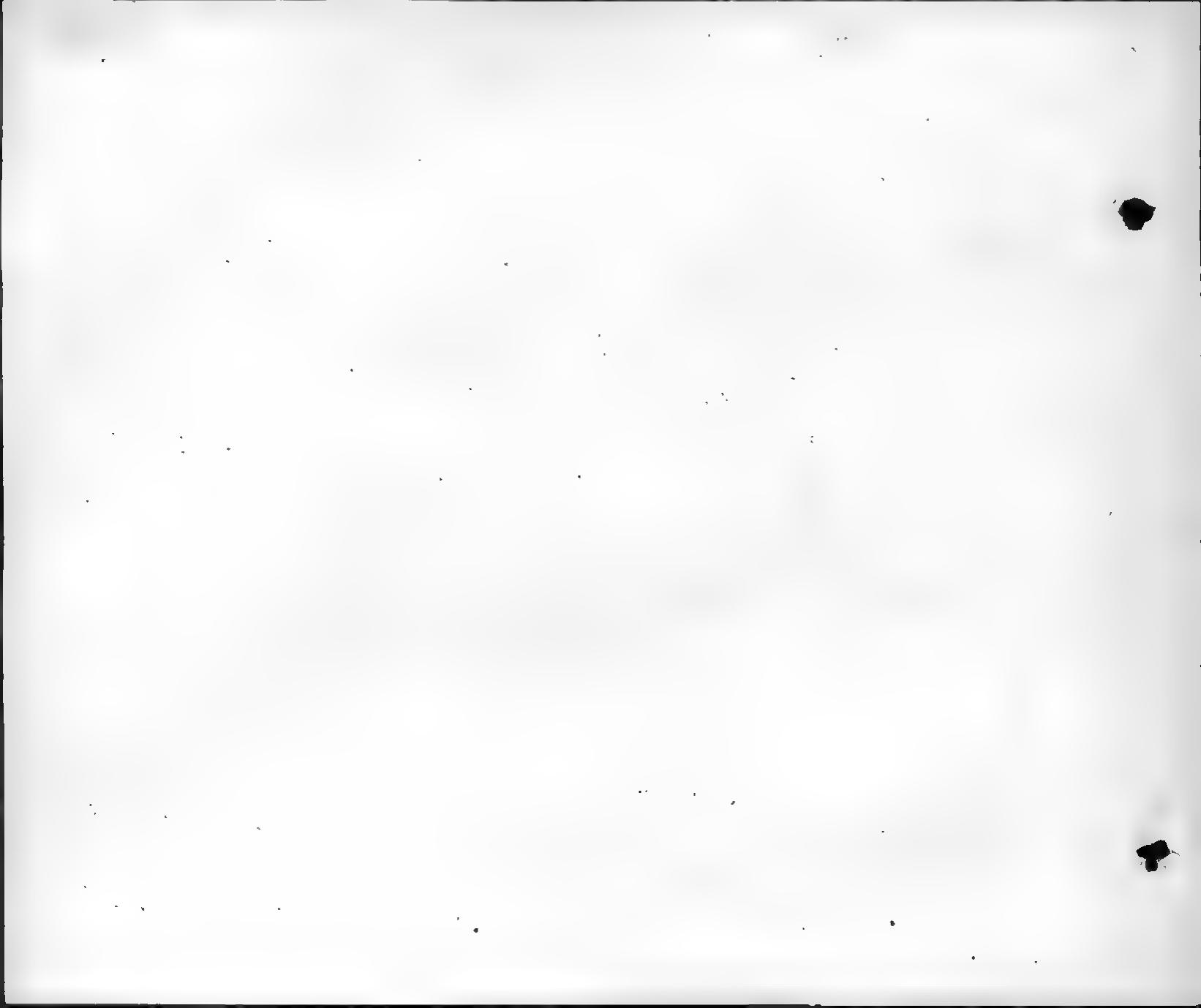
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i></i>

21. I certify that I attended the deceased from <i>July 1, 1956</i> to <i>Sept 16, 1960</i> that I last saw the deceased alive on <i>September 15, 1960</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i></i>	DATE SIGNED <i>Sept 16, 1960</i>
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ACTUAL SIGNATURE <i>Charles T Harvey</i>	PHYSICIAN'S NAME (Type) <i></i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-19-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Grove</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer Lipton Hampstead Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>SEP 21 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Elmer L. Lipton</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be countersigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if present, within 72 hours after death.

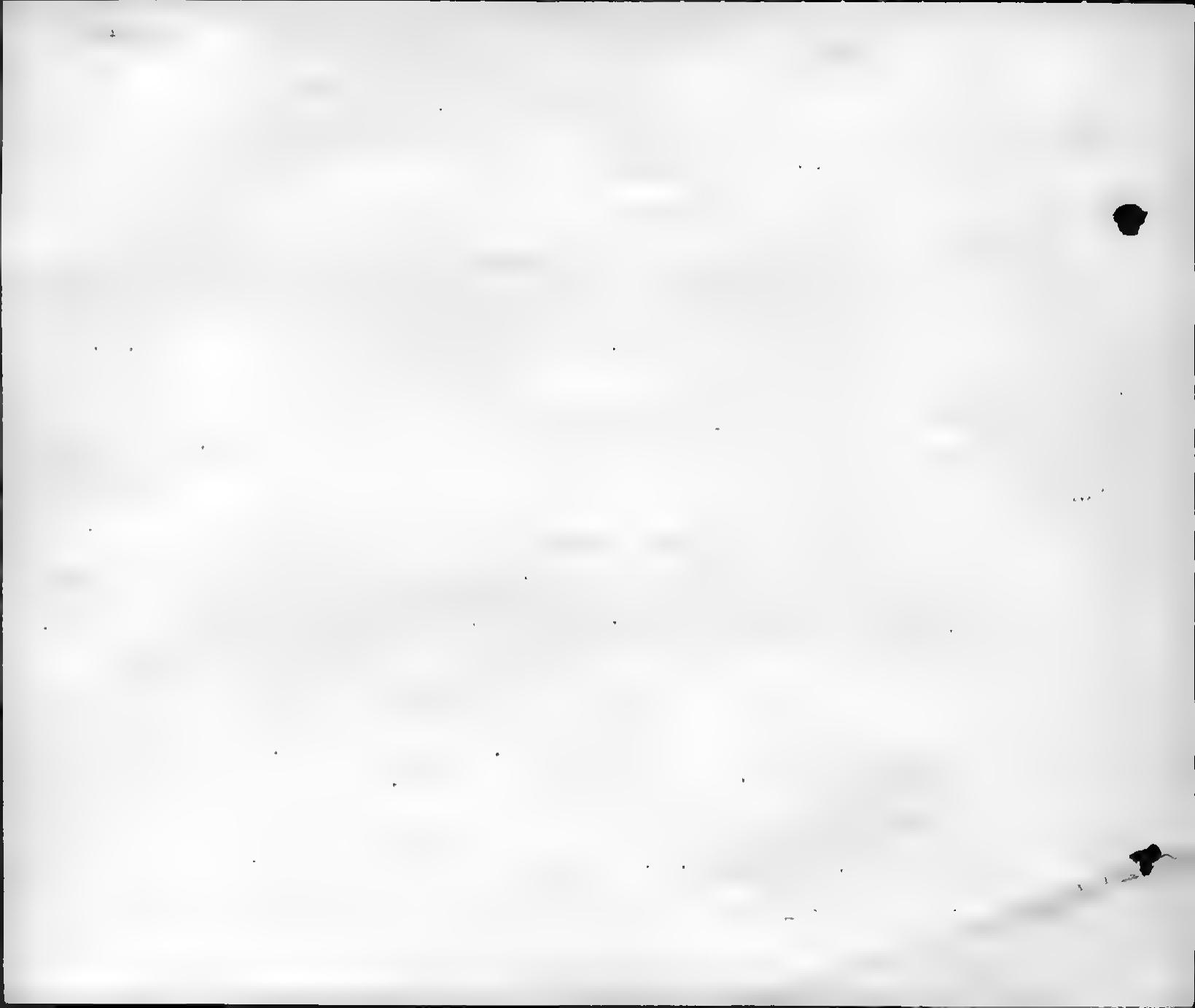
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11C40

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1320 East Fayette Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ANDY		First	Middle	Last	4. DATE OF DEATH September 27, 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1919	9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Chester, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Clowney				14. MOTHER'S MAIDEN NAME Victoria Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 249-12-3655		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 307X BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 8 DAYS Conditions if any, wh ch gave rise to immediate cause (a), stating the underlying cause last (b) DELIRIUM TREMENS INTERVAL BETWEEN ONSET AND DEATH 10 DAYS (c) CHRONIC ALCOHOLISM INTERVAL BETWEEN ONSET AND DEATH MANY YEARS								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASSE CONDITION GIVEN IN PART I(a) TUBERCULOSIS ARRESTED; LAENNEC'S CIRRHOSIS; POLYNEURITIS								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 14, 1960 to Sept. 27, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 27, 1960 , and that death occurred at p. M. , from the causes and on the date stated above.								
22a. SIGNATURE <i>Frederick S. Donaldson</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M. D.		22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-30-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town or county) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson		ADDRESS 2004 Orleans St Baltimore 31 Md		25a. REC'D BY REGISTRAR OCT 13 '60		25b. REGISTRAR'S SIGNATURE <i>Elroy O. Wilson</i>		





TO DEPT. OF STATE
This certificate should be executed within 24 hours after death. If execution is delayed, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

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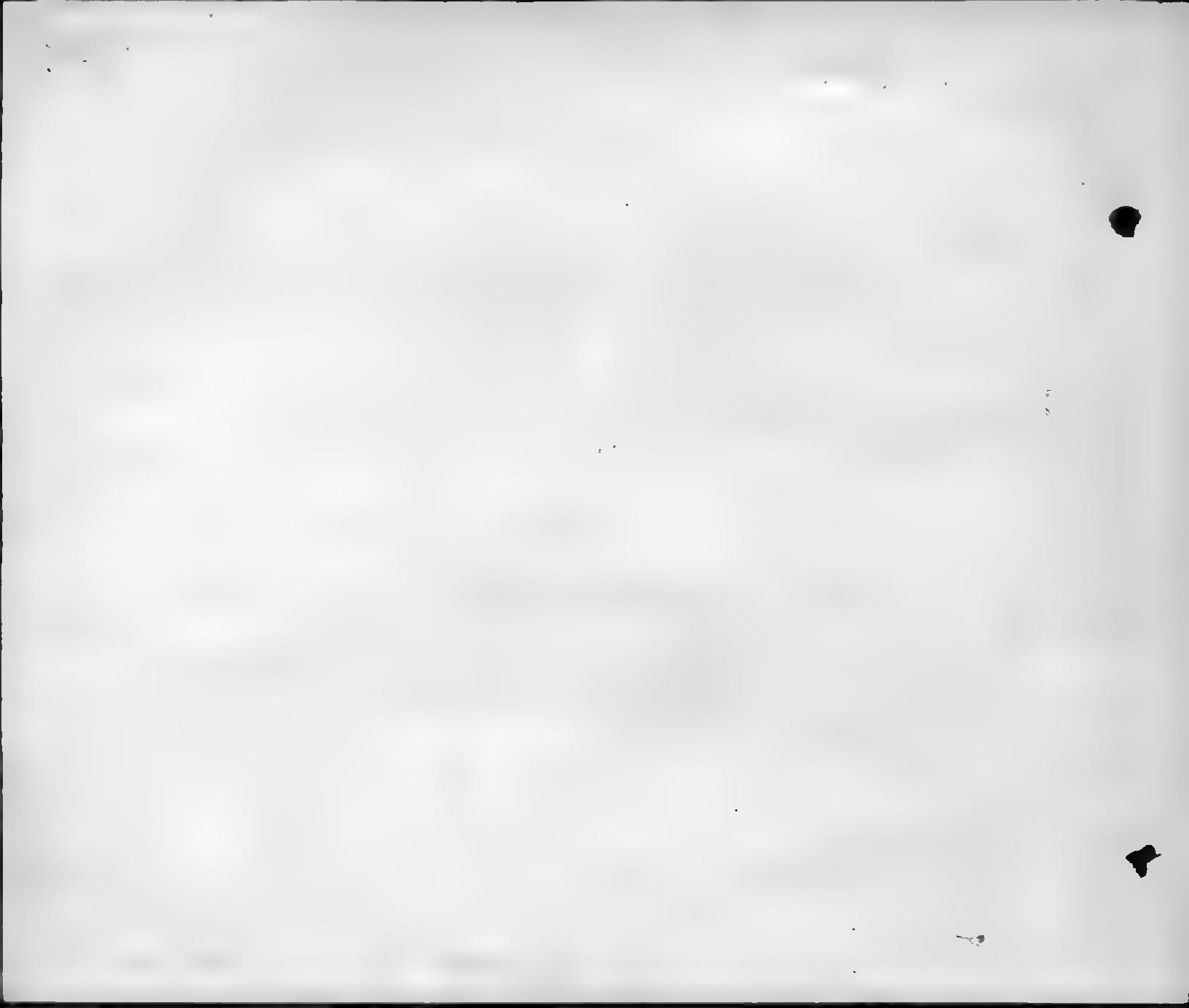
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05932

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
BALTIMORE		MARYLAND		54 days		a. STATE 724 b. COUNTY 522		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Baltimore City Hospital		Baltimore		6th and St Paul		YES <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
JESSE		CLARK	C. L. L. K.	8-4-1873	Sept	15	1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
Male		White		8-4-1873		87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Teacher		Va. Schools		Tennessee		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
George M. Johnson		Edith Williams Brown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		232-36-7894		Butcher for George P. Clark				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <u>Respiratory failure due to heart disease</u> <u>over 2 weeks</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure due to heart disease</u> <u>over 1 year</u> (c) <u>inhalation of Expectorant</u> <u>1 month</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes - arteriosclerosis of the heart</u> <u>over 6 months</u>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Decerebrate position found last night 8/2/60</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30 p.m. 8-4-15-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>D. D. Tracy 68</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>D. D. Tracy</u>		DATE SIGNED <u>8-15-60</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/17/60</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Shady Grove</u>		22d. LOCATION (City, town, or county) <u>Frederick, Md.</u> (State) <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. CAPLES</u>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>John S. Tracy</u>		
				DATE SEP 19 '60				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

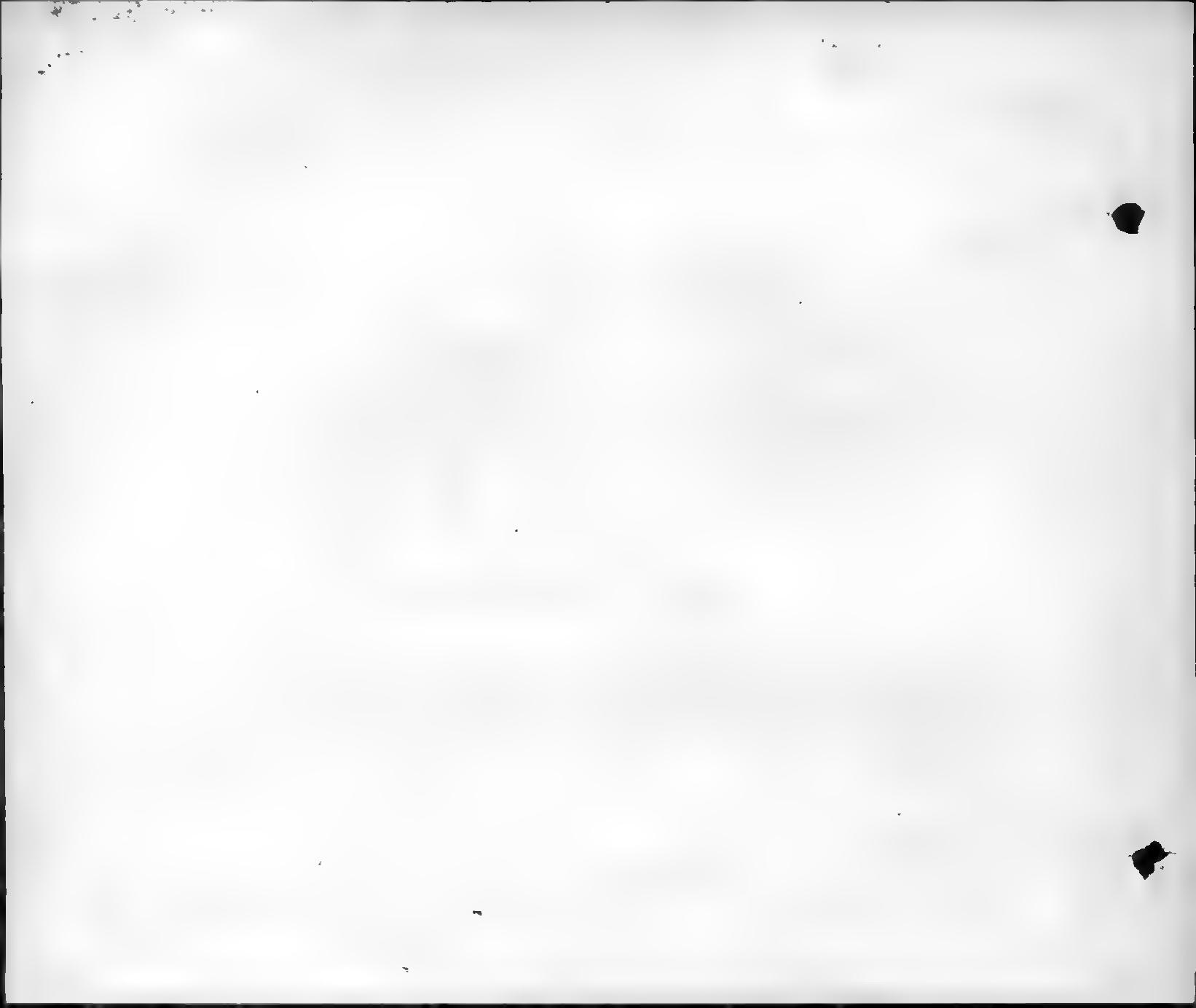
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09933

9978

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, 17, Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Baltimore State Training School</i>		d. STREET ADDRESS <i>1708 North Luton Place</i>	
3. NAME OF DECEASED (Type or print)	First <i>Kerwin</i>	Middle <i>Conn</i>	Last Month Day Year <i>September 3, 1960</i>
S SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-6-60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Eugene Lawson Conn</i>	14. MOTHER'S MAIDEN NAME <i>Carrie Elizabeth Douglas</i>	Address <i>Rosewood Records</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Extensive hydrocephalus complicated by aspiration of stomach content			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>Rosewood Cemetery</i>	20f. (City or town) (County) (State) <i>Owings Mills Md</i>
21. I certify that (I) (this hospital) attended the deceased from <i>8-16</i> to <i>9-3</i> , 1960, that (I) (we) last saw the deceased alive on <i>9-3</i> , 1960, and that death occurred at <i>11 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>R.W. Rieckert</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>9-4-60</i>
22c. PHYSICIAN'S NAME (Type) <i>R.W. Rieckert</i>		22d. ADDRESS <i>4307 Mainfield Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept 7-1960</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rosewood Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Owings Mills Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Glone Sons Funeral Home</i>		ADDRESS <i>25a. REC'D BY REGISTRAR DATE SEP 8 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Lewis</i>



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			Item # 411623 10-17-60 et 109334		
1. PLACE OF DEATH a. COUNTY			9979 Dr. St. 12 Fls. Spring Grove State Hosp. Baltimore Co., Maryland			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)			a. STATE			b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Catonsville			c. LENGTH OF STAY IN lb			6 yr. 7 mo. 8 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			Spring Grove State Hosp.			d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			LAST S. Middle Elizabeth			FIRST C. E.			4. DATE OF DEATH			Month 9	Day 30	Year 1960			
5. SEX F			6. COLOR OR RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday) 78 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			House wife.			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME			Jacob Metz			14. MOTHER'S MAIDEN NAME			U. V.			U. S. A.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT			Address			Baltimore, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death due to heart failure																	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure (c) Due to high blood pressure due to heart failure																	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above																	
22a. SIGNATURE			M.D.			ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						22d. DATE SIGNED 9.3.60 1960					
23a. BUR. AL. CREMATION OR REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town, or county)			(State)					
Burial			9/6/60			Mt. Zion Evangelical Church			Locust Grove Wash. Co. Md.								
24. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Prest Harvey Funeral Chapel Hagley Hwy. W. Va. L. Morris			Md.			DATE SEP 7 '60			Charles S. Evans								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9980 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09935

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Box 372, Walnut Grove Rd.

3. NAME OF
DECEASED
(Type or print)First
JOHNMiddle
WAYNEalso Edwards
CORNETT4. DATE
OF
DEATHMonth
September
Day
28
Year
1960

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED
WIDOWED
DIVORCED

8. DATE OF BIRTH

8/19/60

9. AGE (In years
last birthday)
yrs.IF UNDER 1 YEAR
Months
1
Days
5
Hours
160
Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore,
Md.

13. FATHER'S NAME

Unknown Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or dates of service)

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last,

DUE TO

(b)

DUE TO

(c)

Interstitial pneumonitis

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Dollie Cornett - Box 372 Rt. 1, Balto. 21

Address

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work Not White at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/28/60

SIGNATURE

W. Bradley King, Jr., M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

22d. LOCATION (City, town, or country)

(State)

Burial 9/30/60 Loudon Park Cem.

23. FUNERAL DIRECTOR

John J. McPhee & Sons - Baltimore, Md.

ADDRESS DATE REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE OCT 3 '60

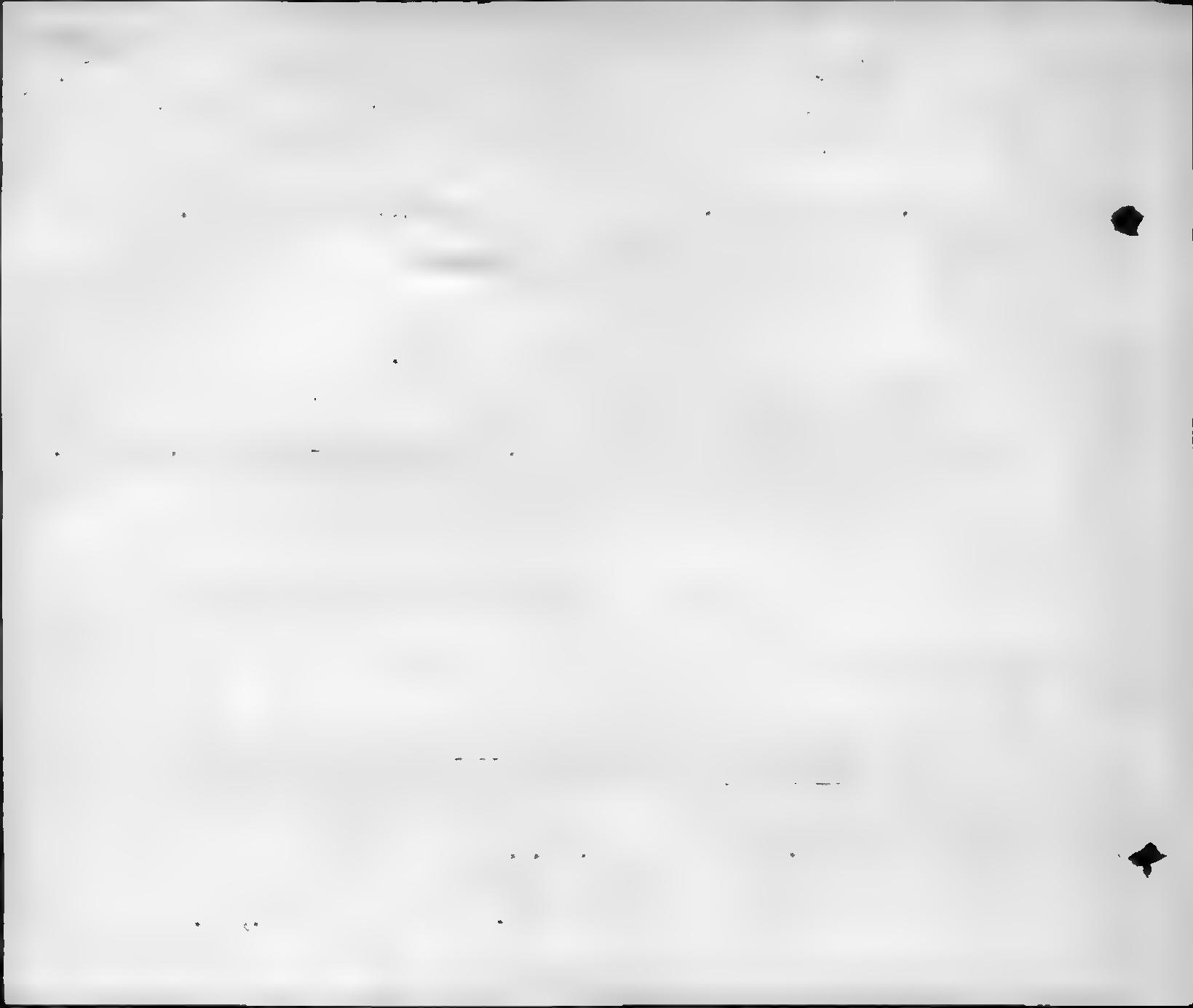
Cathleen S. Keane

Nurs

ADDRESS DATE REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE OCT 3 '60

Cathleen S. Keane



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

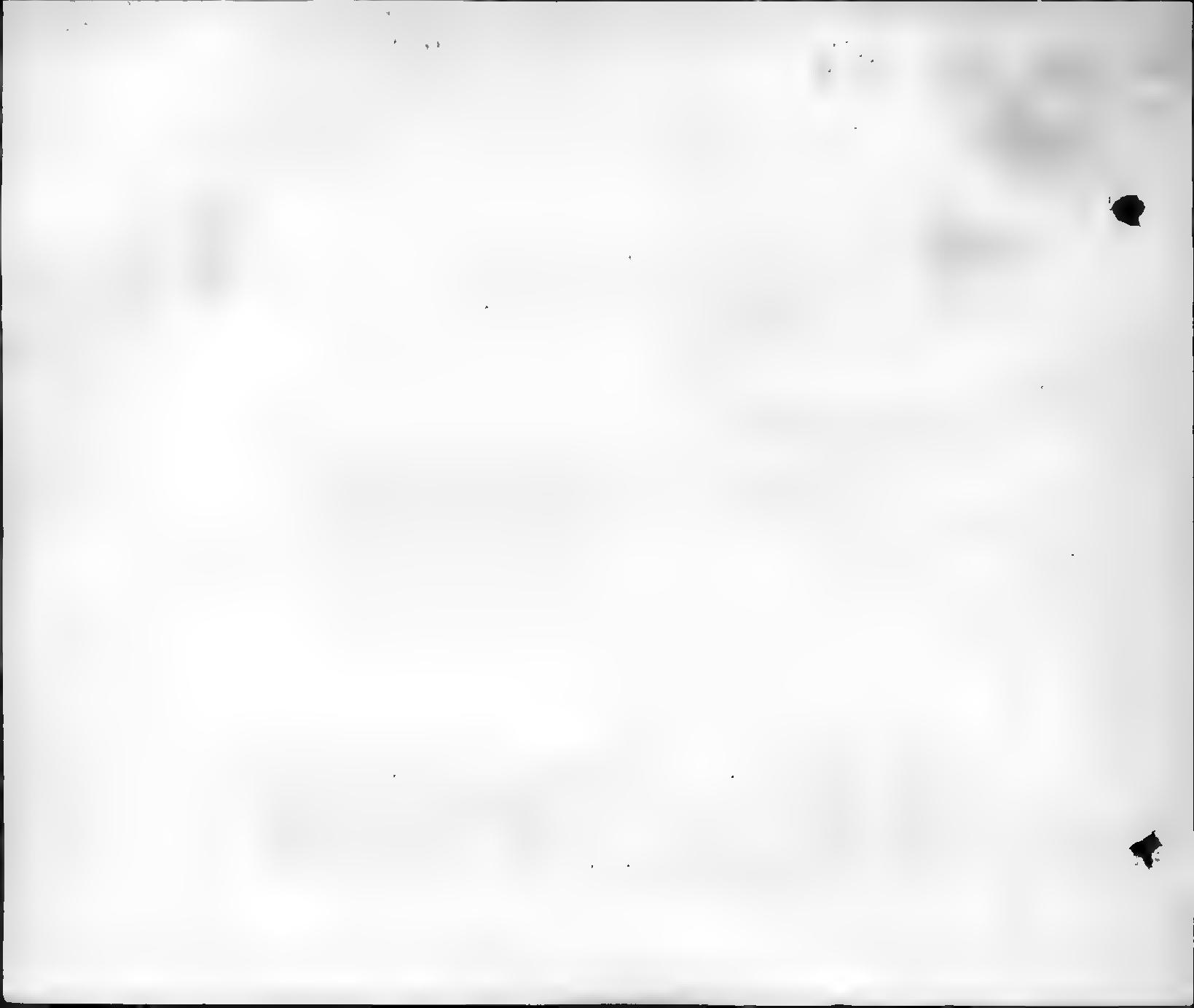
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09936

9981

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24yr1mth14days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY Baltimore			
						CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sparks, Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS X Sparks, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Naoma	Middle M.	Last Costa	4. DATE OF DEATH September 1 1960	Month	Day	Year				
S SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1904		9. AGE (in years last birthday) 55 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min					
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Our home		12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME Charles Wertz				14. MOTHER'S MAIDEN NAME Clara May Knapp				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown, If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive cardiovascular disease DUE TO (c) Infarctive myocardial fibrosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemorrhagic colitis - undetermined etiology										INTERVAL BETWEEN ONSET AND DEATH	
										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Aug. 4 1960		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1 1960 to Sept. 1 1960, that (I) (we) last saw the deceased alive on Sept. 1 1960, and that death occurred at 7:15 A.M. from the causes and on the date stated above										22b. DATE SIGNED 9-1-60	
22a. SIGNATURE Stella Wachsler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS SPRING GROVE STATE HOSPITAL							
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.											
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 4, 1960		23c. NAME OF CEMETERY OR CREMATORIAL New Freedom Cem.		23d. LOCATION (City, town, or county) New Freedom, Pa.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Jacob H. Hirsch New Freedom, Pa.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REC'D BY REGISTRAR'S SIGNATURE John H. Hirsch					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

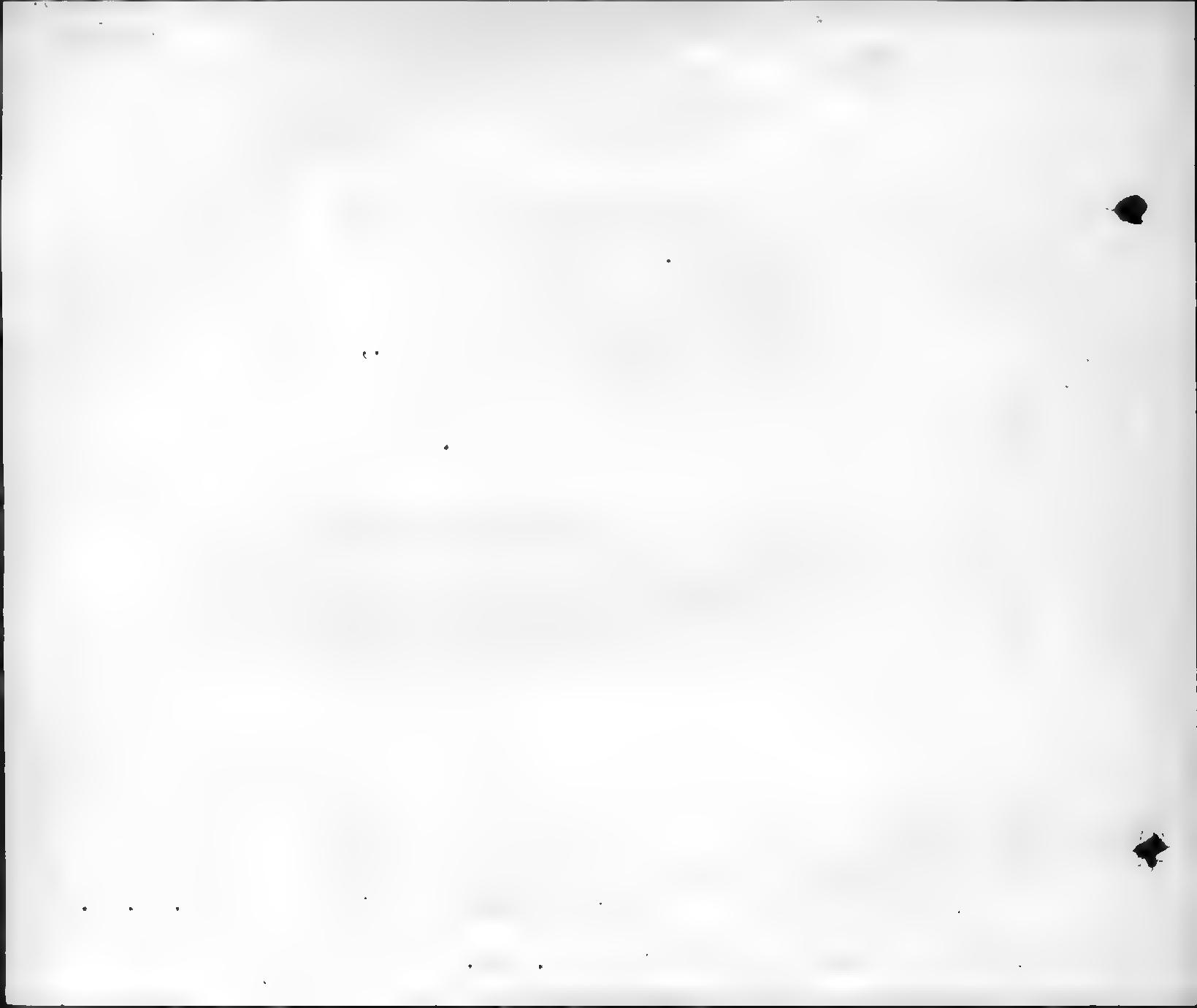
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09937

9982

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Md.	
BALTIMORE MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 2 yr. 5 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP. 4112		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 BALTIMORE	
3. NAME OF DECEASED (Type or print)		First Ann	Middle E. (Cremen)
Last Cremen		4. DATE OF DEATH Sept 16	Month Sept Year 1960
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-16-78		9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Md., Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Matthew O'Neil	
14. MOTHER'S MAIDEN NAME Ann Mahaney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hosp. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450- Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO DUE TO DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15 1958 to Sept 16 1960 that (I) (we) last saw the deceased alive on Sept 16 1960 and that death occurred at 11PM , from the causes and on the date stated above			
22a. SIGNATURE Peter C. Y. Tchen		22b. DATE SIGNED 22	
22c. PHYSICIAN'S NAME (Type) PETER C. Y. TCHEN		22d. ADDRESS 116 ALLEN Rd. GLEN BURNIE MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/60	
23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		23d. LOCATION (City, town, or county) Pikesville, Balto. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lommon		ADDRESS 4611 Park Heights Ave. Balto.	
25a. REC'D BY REGISTRAR SEP 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



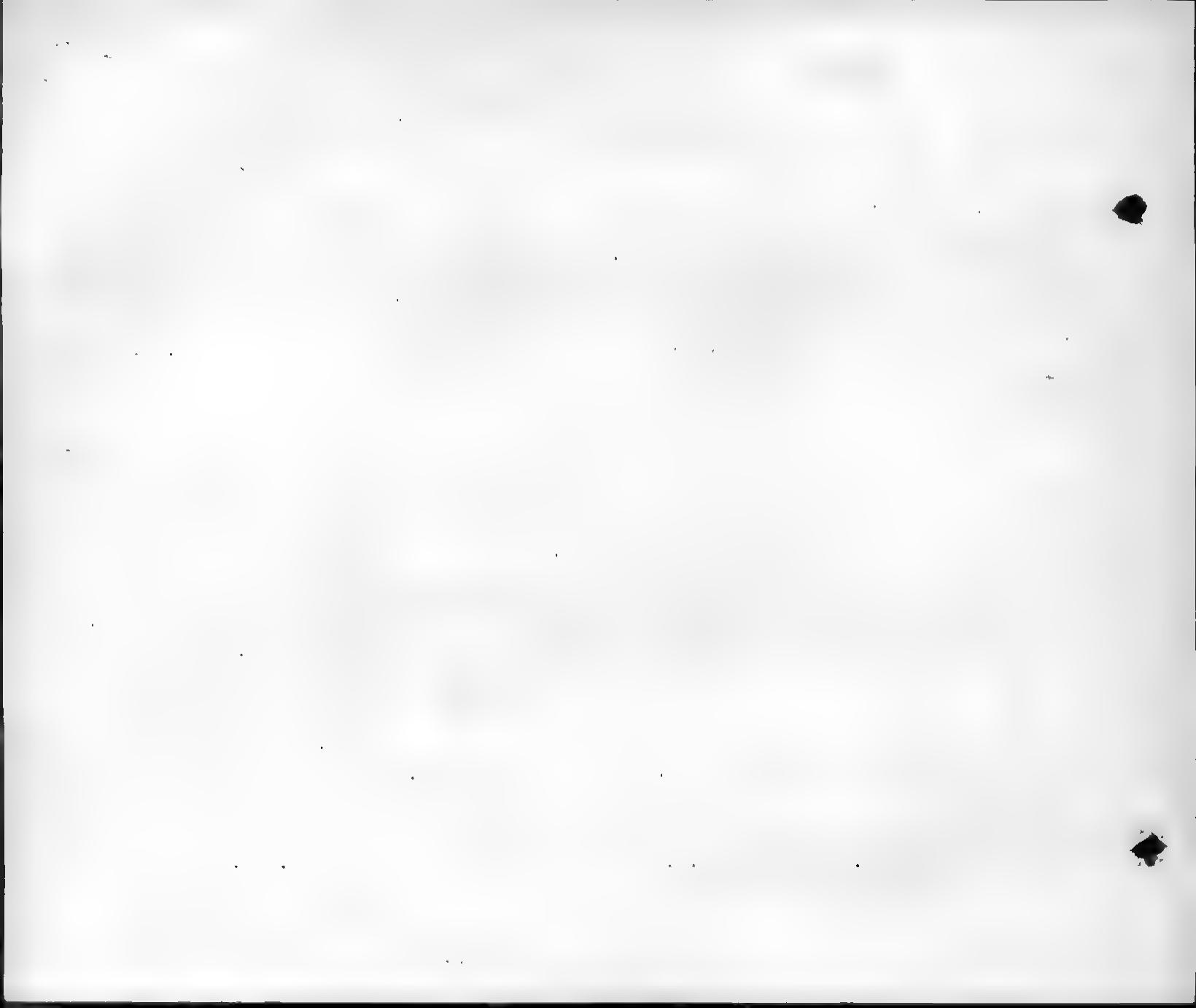
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09938

9983		CERTIFICATE OF DEATH											
1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 31 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Baltimore (22)									
d. NAME OF HOSPITAL (If not in hospital, give street address) o. INST TUT ON Veterans Administration Hospital		d. STREET ADDRESS 2443 Fairway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) LEONARD		First	Middle	Last	4. DATE OF DEATH	Month		Day		Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1888		9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min. 0				
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joshua Cross		14. MOTHER'S MAIDEN NAME Ellen MN: Snyder											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 705-10-9668		17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DIFFUSE HEMORRHAGIC EROSIONS OF THE STOMACH WITH 540.5 XMAS ASPIRATION INTO THE LUNGS													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) OLD CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION, UNKNOWN XMAS CIRCUMFLEX ARTERY													
(c)													
INTERVAL BETWEEN ONSET AND DEATH 4 HOURS													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
GENERALIZED ARTERIOSCLEROSIS													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 15, 1960 to September 15, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 15, 1960 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Frederick S. Donaldson		M.D. <input type="checkbox"/> ATTENDING PHYS		<input type="checkbox"/> MED. DIRECTOR		<input checked="" type="checkbox"/> STAFF PHYS		22b. DATE SIGNED 9/15/60					
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National				23d. LOCATION (City, town, or county) Baltimore		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.													
ADDRESS						25a. REC'D. BY REGISTRAR SEP 21 1960		25b. REGISTRAR'S SIGNATURE Clifford S. Francis					
DATE													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

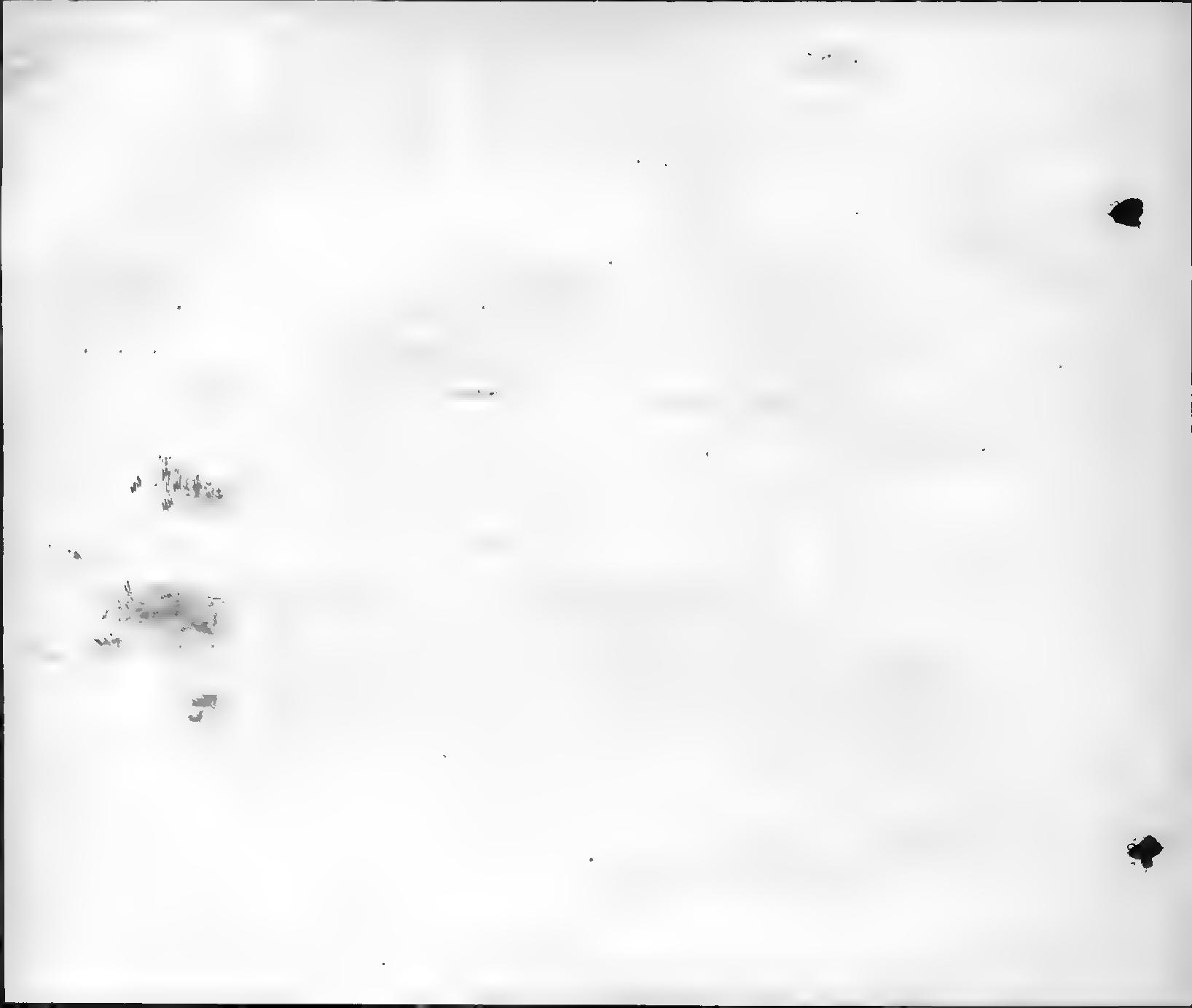
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If either, notify medical examiner. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon from pages 1 and 2 should be held with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09939

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland	
f. STREET ADDRESS 200 Cherry Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle W.	Last Crubaugh
4. DATE OF DEATH	Month September	Day 14	Year 1960
S SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 26, 1877
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Utility	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Robert Crubaugh		14. MOTHER'S MAIDEN NAME Unknown Sarah E. Rankin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown no		16. SOCIAL SECURITY NO. Unknown none	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Right-sided hypertrophy and failure of heart DUE TO (c) Pulmonary fibrosis			
INTERVAL BETWEEN ONSET AND DEATH 14 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal ulcer			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Sept. 14 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove State Hospital		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 22 1960 to Sept. 14 1960 , that (I) (we) last saw the deceased alive on Sept. 14 1960 , and that death occurred at 8:00 A.M. from the causes and on the date stated above			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 9-14-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran		23d. LOCATION (City, town or county) (State) Joppa, Harford, Md.,	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son		25a. REC'D BY REGISTRAR DATE SEP 19 1960	
ADDRESS Abingdon, Md.,		25b. REGISTRAR'S SIGNATURE Arthur J. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9937

CERTIFICATE OF DEATH

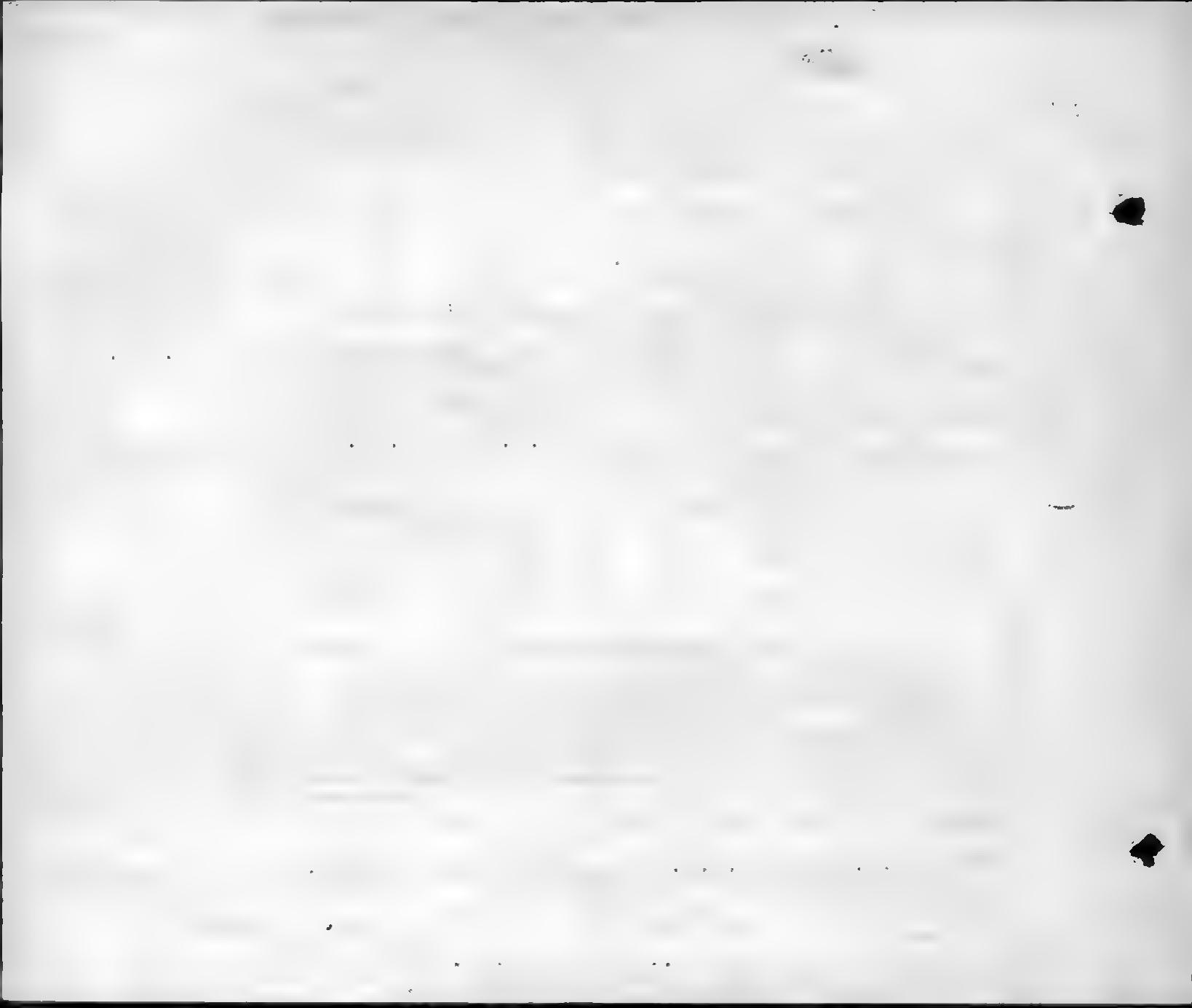
Reg. Dist. No.

09940

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3309 Sollers Point Road		d. STREET ADDRESS 3309 Sollers Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CAMILLE		First C.	Middle CURINGA	4. DATE OF DEATH September 20th, 1960	Month September	Day 20	Year 1960		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1909	9. AGE (In years at birthday) 51 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ceaser A. Garafoli		14. MOTHER'S MAIDEN NAME Philmeno Benedict							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-05-8904		17. INFORMANT A.E. Curinga, Sr., same as #2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		DUE TO Arteriosclerotic cardiovascular disease				5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6118 1/2 Dundalk Avenue		20f. (City or town) Dundalk		(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from 9/18/60 , 1960, to 9/20/60 , 1960, and that death occurred at 9:15 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 3401 Dundalk Avenue		DATE SIGNED 9/22/60	
ACTUAL SIGNATURE W.E. Baermann									
PHYSICIAN'S NAME (Type) W.E. Baermann, M.D.						Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/60		22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Memorial		22d. LOCATION (City, town, or county) Dorsey, Maryland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 26 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 36 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5a Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 59 N. Prospect Avenue	d. STREET ADDRESS 59 N. Prospect Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Freida Dorn	First Middle Last	4. DATE OF DEATH Sept. 27, 1960	Month Day Year		
S. SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1879		
9. AGF (In years last birthday) 80 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Julias Haas		14. MOTHER'S MAIDEN NAME Catherine Fishback			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-8147-4		INFORMANT Mr. Raymond Dorn St. Johns Jane Ellicott City	Address Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Due To Regenerative D. S. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due To Generalized Arterio-Sclerosis (c)					
INTERVAL BETWEEN ONSET AND DEATH 6 mos					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-12, 1960, to 9-27, 1960, that I last saw the deceased alive on 9-27-1960, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) James S. Howell, M.D. Catonsville ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL. (Specify) Burial		22b. DATE THEREOF 9/30/1960		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	
22d. LOCATION (City, town, or county) Baltimore, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edison Jones		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 3 '60	
				24b. REGISTRAR'S SIGNATURE Albert S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09942

9942

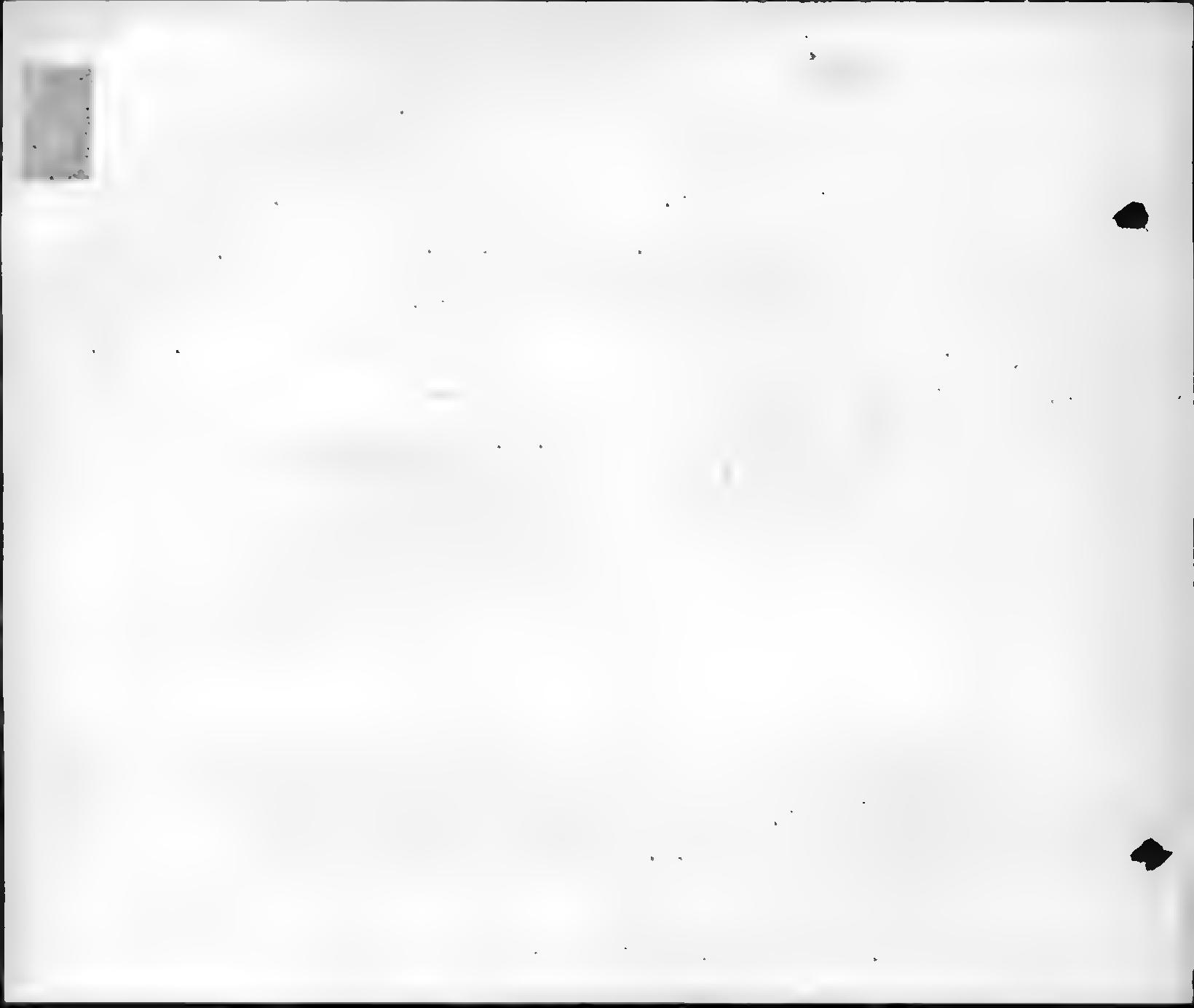
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1705 Selma Ave.			d. STREET ADDRESS 1705 Selma Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) John		Middle Name F. Douthirt, Sr.	Last Name Douthirt	4. DATE OF DEATH Month Sept. 17, 1960	Day Year
S. SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 15, 1861	9 AGE (in years last birthday) 99 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 17. INFORMANT Address Wm. A. Douthirt 1705 Selma Avenue #27		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 427.1 DUE TO Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Generalized A. S. C. V. D. (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to Sept. 17, 1960, that (I) (we) last saw the deceased alive on Aug. 1960, and that death occurred at 10 M, from the causes and on the date stated above			22b. DATE SIGNED		
22a. SIGNATURE John G. Healy, M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) John Healy, M.D.		22d. ADDRESS Francis Avenue			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/60	23c. NAME OF CEMETERY OR CREMATORIALY Loudon Park Cemetery	23d. LOCATED ON (City, town, or county) Baltimore, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	25a. REC'D BY REGISTRAR DATE SEP 21 '60	25b. REGISTRAR'S SIGNATURE Lorraine L. Thomas	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 [4]
1SM II/S9

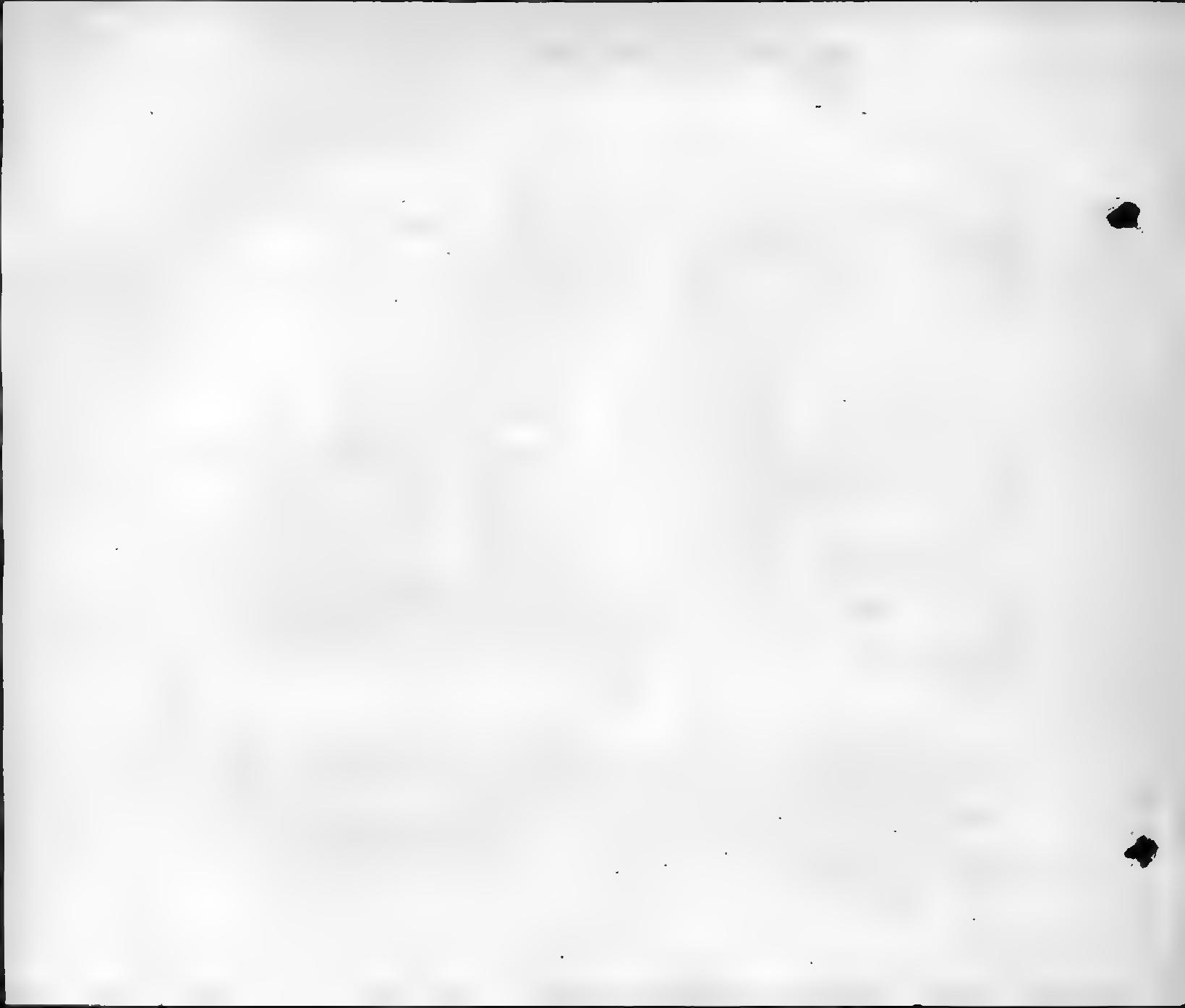


FOR STATE
HEALTH DEPT.

1
1
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AISME
SM 2/37

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09944

9987

1. PLACE OF DEATH a. COUNTY		Rosewood St. Tr. School Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE		Maryland		3. FILMED 9-23-60 et	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Owings Mills 1 month		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore City Hospital 235			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Rosewood State Training School		e. STREET ADDRESS		1714 W. Fayette St. 14940 Eastern Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Bill	Middle	Last Easter	DATE OF DEATH	Month 9	Day 12	Year 1960	
4. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Male Negro WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years lost birthday) yrs. F. UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Baltimore, Maryland		U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Rosewood St. Tr. School,		Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		571.0		Gastro-enteritis acute etiology not determined microcephalic infant		INTERVAL BETWEEN ONSET AND DEATH 3 weeks - Birth			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-11, 1960, to 9-12, 1960, that (I) (we) last saw the deceased alive on 9-12 @ 10:45 P.M. and that death occurred at 10:52 P.M. from the causes and on the date stated above.									
22a. SIGNATURE		Harry G. Butler		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9-12-60			
22c. PHYSICIAN'S NAME (Type)		Harry G. Butler, M.D.		22d. ADDRESS		Owings Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL. (Specify)		23b. DATE THEREOF 9/15/60		23c. NAME OF CEMETERY OR CREMATORIAL Rosewood Cem.		23d. LOCATION (City, town, or county) Owings Mills		(State) 140	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS J. F. Eline & Sons Reisterstown Md.		25a. REC'D BY REGISTRAR SEP 19 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline			

IVV VV VVX ..



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 09945									
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH o COUNTY		Baltimore H. Md.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		o STATE Md.			b COUNTY H. Baltimore M.								
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)				c LENGTH OF STAY IN lb H. 34 yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Hyde, Md.				d. STREET ADDRESS		Hyde			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First GEORGE		Middle HOWARD		Last ELDER, SR.		4. DATE OF DEATH		Month SEPT.		Day 28		Year 1960					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1891		9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours					
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-8-1893													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Farmer				Self				Balto., Co City				U.S.A.							
13. FATHER'S NAME George H. Elder										14. MOTHER'S MAIDEN NAME Frances Norris									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES				16. SOCIAL SECURITY NO. W.W. 1 215-32-1250				INFORMANT George Elder, Jr.				Address Hyde Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH one-half hour									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Coronary Insufficiency DUE TO 20 years																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I attended the deceased from 1956, 19, to September, 1960, that I last saw the deceased alive on 26 September, 1960, and that death occurred at 10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Walter T. Kees PHYSICIAN'S NAME (Type) Walter T. Kees, M.D.										ADDRESS (Street, city or town, state) Cockeysville, Maryland DATE SIGNED 28-Sept-1960									
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-1-1960		22c. NAME OF CEMETERY OR CREMATORIUM TRINITY CEMETERY				22d. LOCATION (City, town, or county) LONG GREEN MARYLAND		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE BROOKS FUNERAL SER. 622 YORK RD. TOWSON										ADDRESS		24a. REC'D BY REGISTRAR OCT 4 '60		24b. REGISTRAR'S SIGNATURE Cynthia S. Kees					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

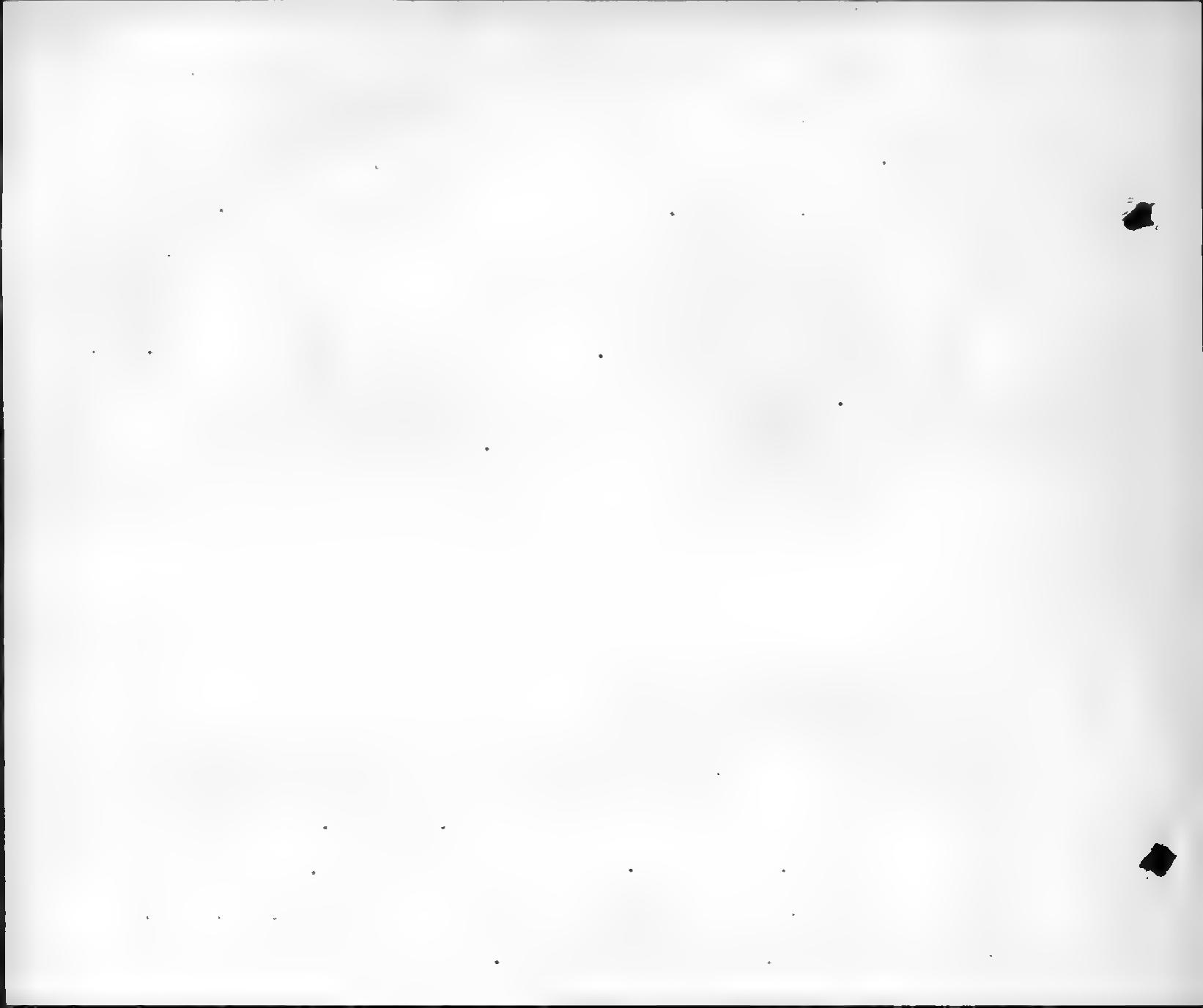
CERTIFICATE OF DEATH

Reg. Dist. No.

69946

9989

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 717 Goucher Blvd.		d. STREET ADDRESS 717 Goucher Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARIE WILSON ELDRIDGE		First	Middle	Last	4. DATE OF DEATH Month Day Year 9-11 19 60	Month	Day	Year	
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1906	9. AGE (in years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File clerk		10b. KIND OF BUSINESS OR INDUSTRY auto mfg.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward B. Wilson		14. MOTHER'S MAIDEN NAME Carrie Ginn							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Lee M. Eldridge,		Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.									
18mo.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) 20f. (City or town) Baltimore	(State) 20f. (City or town) Baltimore
21. I certify that I attended the deceased from 1958 , 19, to death , 19, that I last saw the deceased alive on 10 Sept. , 19 64 , and that death occurred at 2nd A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) William K. Diehl, M.D.									
DATE SIGNED 12-6-64-66									
ACTUAL SIGNATURE William K. Diehl									
PHYSICIAN'S NAME (Type) William K. Diehl, M. D.									
Baltimore 2, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.		(State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 14 '60		24b. REGISTRAR'S SIGNATURE Albert S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9990

CERTIFICATE OF DEATH

Reg. Dist. No. 09947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lives here</i>	c. LENGTH OF STAY IN lb <i>Preserves</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hillside</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>6225 Robin Hill Road</i>	d. STREET ADDRESS <i>6225 Robin Hill Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Philip Isaacs</i>	First <i>Philip</i>	Middle <i>J</i>	Last <i>Isaacs</i>			
4. DATE OF DEATH <i>7-24-1960</i>	Month <i>7</i>	Day <i>24</i>	Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>71 yrs.</i>	9. AGE (In years last birthday) <i>71 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>London, Eng</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Philip Isaacs</i>		14. MOTHER'S MAIDEN NAME <i>Ruth</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO <i>None</i>		INFORMANT <i>Samuel Fischer</i>		Address <i>Same</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hyperthyroid cardiovascular disease</i> DUE TO <i>Hyperthyroidism</i>						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) (County, State) <i>Baltimore</i>
21. I certify that I attended the deceased from <i>Sept 24, 1960</i> to <i>Sept 24, 1960</i> that I last saw the deceased alive on <i>Sept 24, 1960</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above						
ADDRESS (Street, city or town, state) <i>1515 Park Heights Ave - 7115 - 9-4-100</i>						
DATE SIGNED <i>15-10-1960</i>						
ACTUAL SIGNATURE <i>Bernard R. Shiebel, M.D.</i>						
PHYSICIAN'S NAME (Type) <i>Bernard R. Shiebel, M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-25-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rosedale</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Eastern Ave</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 27 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Smith</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09948

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Havard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alice</i>		First	Middle	4. DATE OF DEATH <i>Front Klin</i>	Month	Day	Year <i>September 5 1960</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 23 1874</i>	9. AGE (in years last birthday) <i>85 yrs</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Name</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob B. Sander</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Lewis</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Ella Baker, Ellicott City, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422</i>				Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>Degeneration of Heart Disease</i>		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>819/6049</i>		20f. (City or town) (County) (State) <i>9/5/6019</i>	
21. I certify that I attended the deceased from alive on <i>9/5/60</i> to <i>9/5/6019</i> , and that death occurred <i>9/5/6019</i> from the causes and on the date stated above						ADDRESS (Street, city or town, state) <i>1303 Frederick Rd</i>	
ACTUAL SIGNATURE <i>W.E. McGrath</i>				M.D.		DATE SIGNED <i>9/6/60</i>	
PHYSICIAN'S NAME (Type) <i>W.E. McGrath</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/8/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Emmanuel Cemetery</i>		22d. LOCATION (City, town, or county) <i>Scagganville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Danaldson, Laurel, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>SEP 13 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Orlina S. Hines</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9992

CERTIFICATE OF DEATH

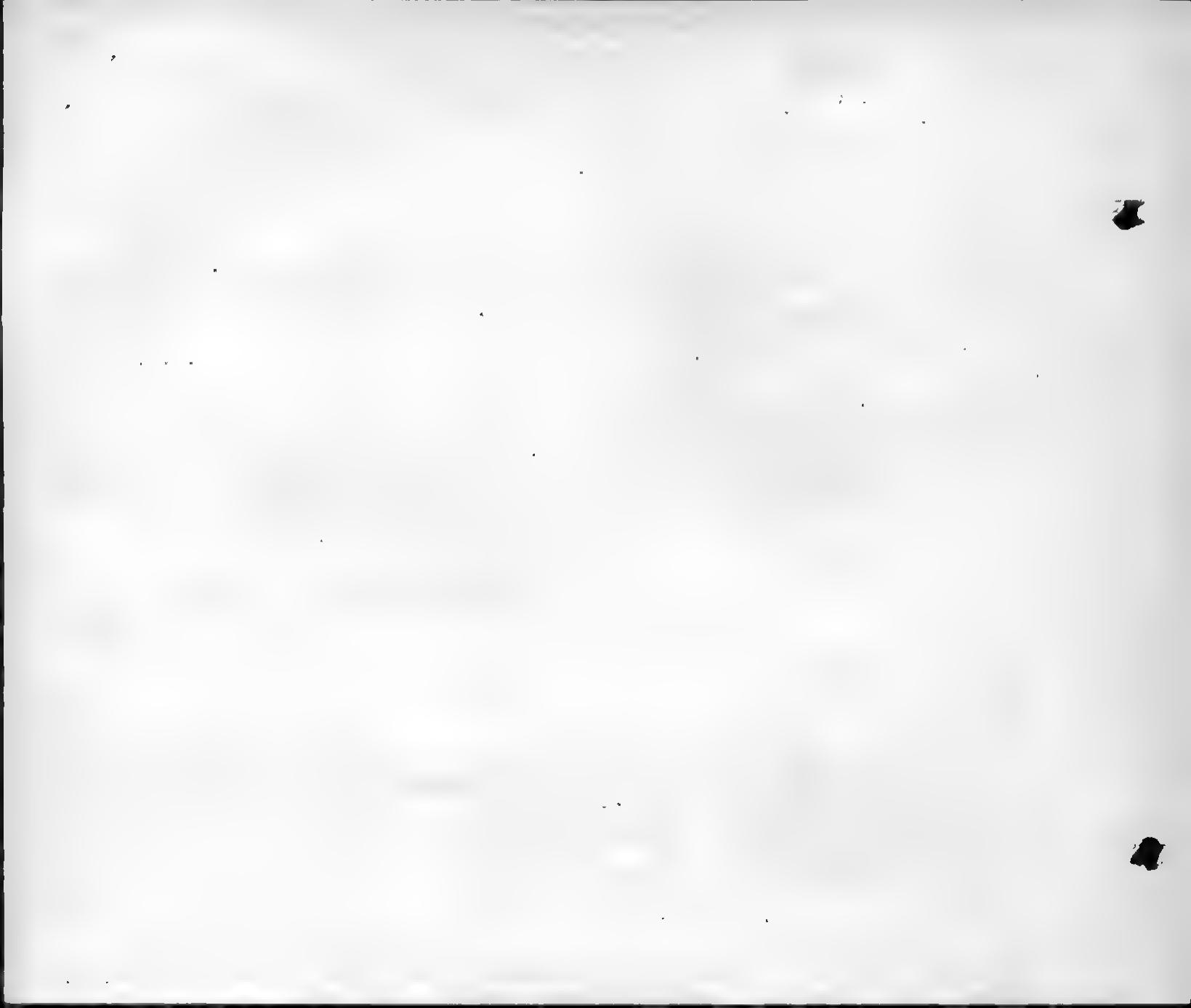
Reg. Dist. No.

09949

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		d. STREET ADDRESS 512 Hawthorn Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines				d. STREET ADDRESS 512 Hawthorn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Robert	Middle Fleetwood	Last Frampton	4. DATE OF DEATH Sept. 7th 1960	Month Sept.	Day 7th	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1 Jan. 1908	C. AGE (In years last birthday) 52 yrs	D. IF UNDER 1 YEAR Months 0	E. IF UNDER 24 HRS Days 0	F. Hours 0	G. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William W. Frampton		14. MOTHER'S MAIDEN NAME Amanda Bell Mast						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mrs. Pauline Frampton Same as no # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Generalized carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 8 m.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Linthicum		(County) (State)
21. I certify that I attended the deceased from Sept. 6, 1960, to Sept. 7, 1960, that I last saw the deceased alive on Sept. 6, 1960, and that death occurred at 10:30 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 528 S. Camp Meade Rd.		DATE SIGNED 9/9/60
ACTUAL SIGNATURE BAHRAM SINHA								
PHYSICIAN'S NAME (Type) BAHRAM SINHA								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10 Sept. 60		22c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery		22d. LOCATION (City, town, or county) Greensborough		(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Sington, Glen Burnie, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Trahan		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal; and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09950

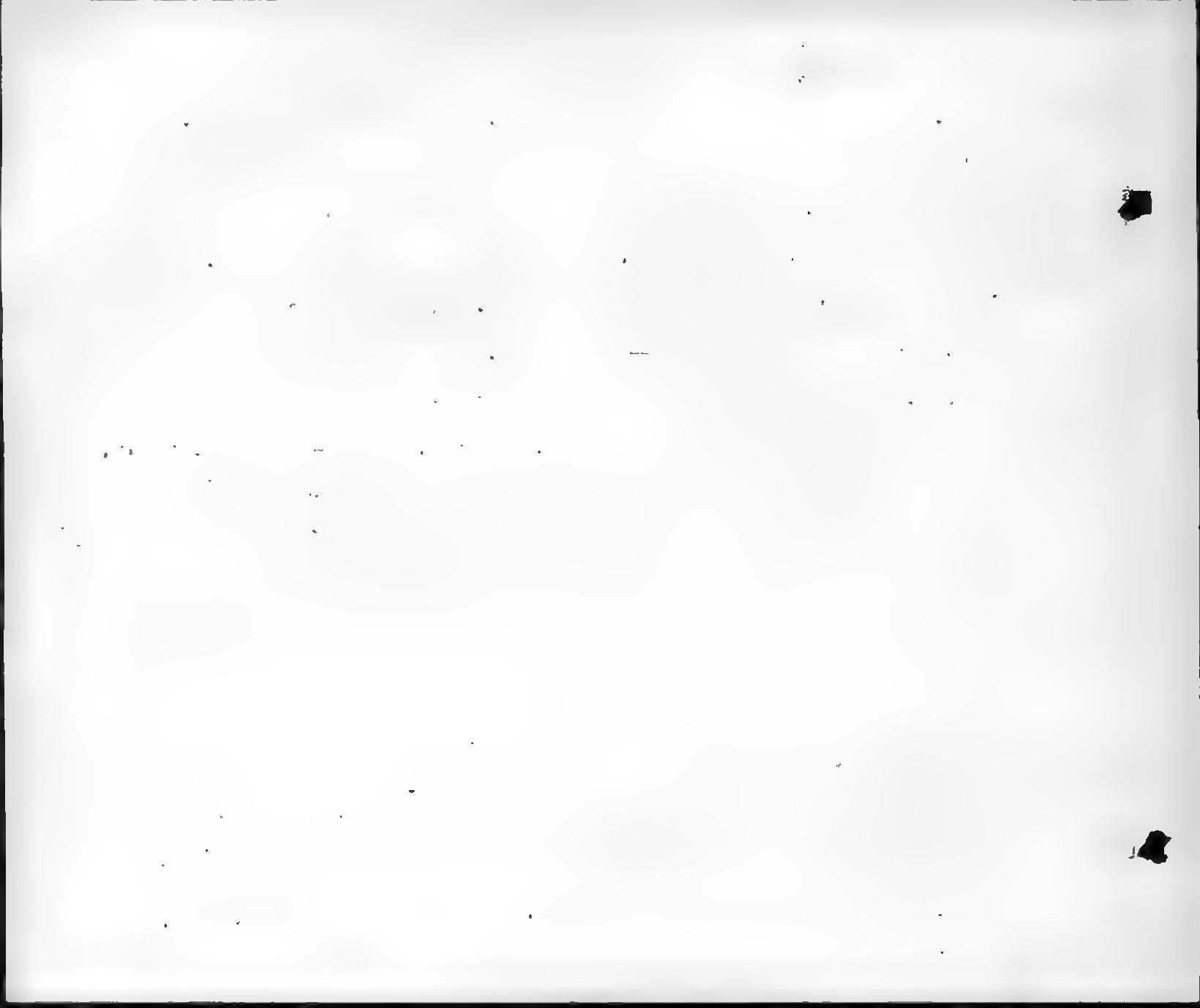
CERTIFICATE OF DEATH

Reg. Dist. No.

9993

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		b. COUNTY Balto.	
c. LENGTH OF STAY IN lb 3522 Millvale Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3522 Millvale Rd.		d. STREET ADDRESS 3522 Millvale Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First OLIVE	Middle RUTH	Last GEIMAN
4. DATE OF DEATH	Month Sept.	Month 23	Day 19
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1893
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Benj. Stafford		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. INFORMANT	12. CITIZEN OF WHAT COUNTRY? Mr. Edward W. Geiman - 3522 Millvale Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 3033 W North St	(County) Balto 16 Md.	(State) Woodlawn, Md.	
21. I certify that I attended the deceased from July 15, 1958 , to Sept 22, 1960 that I last saw the deceased alive on Sept 23, 1960 , and that death occurred at 9:30 a.m. from the causes and on the date stated above			
ACTUAL SIGNATURE Mr. Paul Bixby		ADDRESS (Street, city or town, state) 3033 W North St Baltimore 16 Md.	
PHYSICIAN'S NAME (Type) Paul Bixby		DATE SIGNED 17 Ma	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/60	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Corp.	22d. LOCATION (City, town, or county) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tickner & Sons - Balt		24a. REC'D BY REGISTRAR SEP 27 '60	24b. REGISTRAR'S SIGNATURE C. E. K. Kline



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

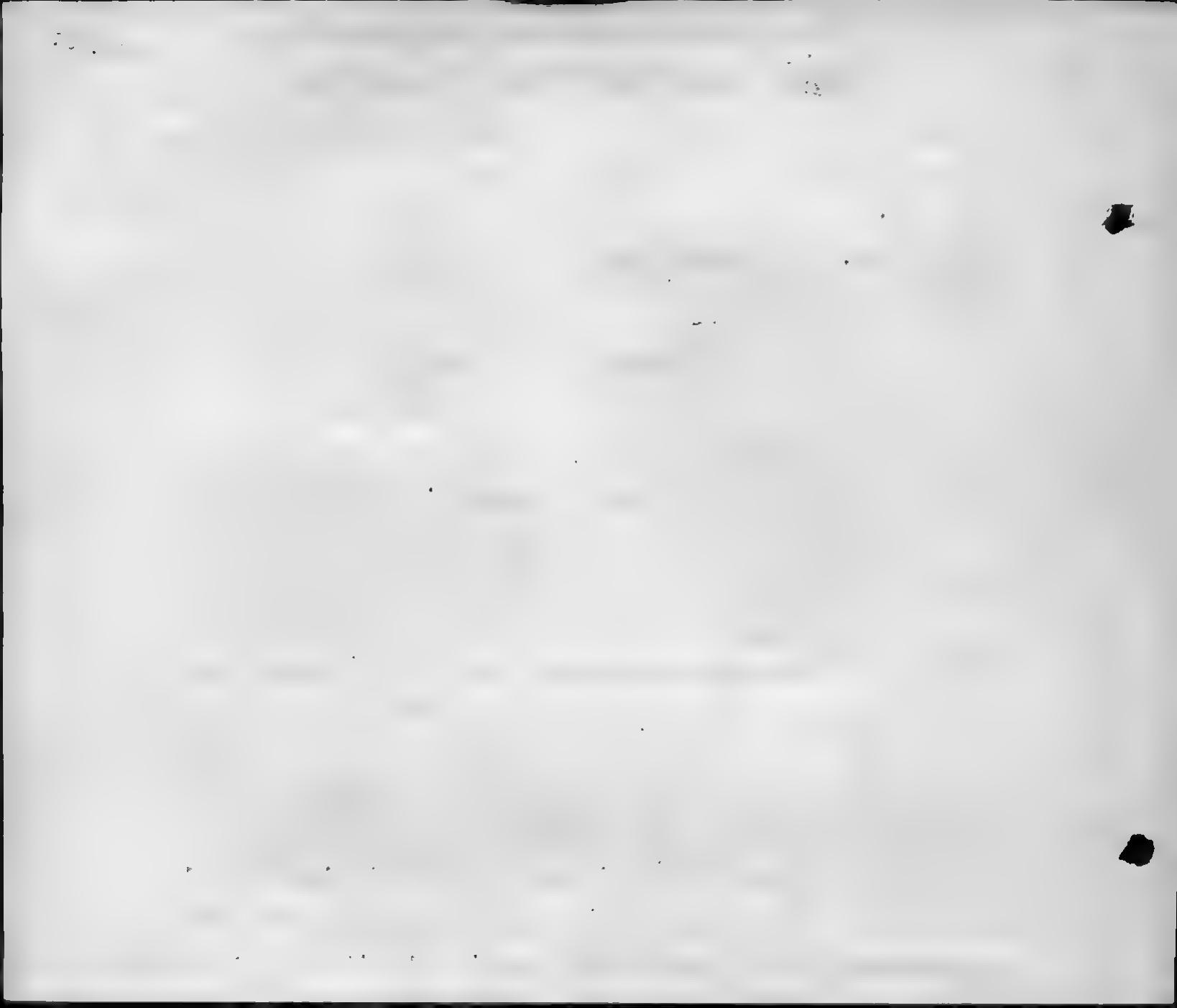
VS A15C-155 10/64

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**9994 CERTIFICATE OF DEATH**

09351

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Mt. Wilson		STATE MARYLAND COUNTY ANNE ARUNDEL CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HANOVER	
LENGTH OF STAY (in this place) 3 MONTHS		STREET ADDRESS BOX 104-B RACE ROAD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital			
3. NAME OF DECEASED (First) WILLIAM (Middle) FRANK (Last) GILL		4. DATE OF DEATH SEPT. 28 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH SEPT. 19 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL FARMING	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME HAMILTON GILL		14. MOTHER'S MAIDEN NAME EMMIE KETTLEBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) UNKNOWN		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Hospital Records Mt. Wilson State Hospital
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1. IMMEDIATE CAUSE (A) PULMONARY TUBERCULOSIS ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. GENERALIZED ARTERIOSCLEROSIS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ... 6/27 ... 1960 ... to ... 9/28 ... 1960 ..., that I last saw the deceased alive on ... 9/28 ... 1960 ..., and that death occurred at 2:30 A.M. from the causes and on the date stated above. SIGNATURE Wm. Newcomer, M.D. ADDRESS (Street, city, town, state) DATE SIGNED 9/28/60			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 9-30-60	
		NAME OF CEMETERY OR CREMATORIUM Finksburg Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE SEP 28 1960		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street	



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 69952		
9995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY PARKVILLE Baltimore County MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN lb Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14			d. STREET ADDRESS 1813 Braircliff Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1813 Braircliff Road												
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
4. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1, 1914	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10b. KIND OF BUSINESS OR INDUSTRY bakery			11. BIRTHPLACE (State or foreign country) Baltimore Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Goetzke					14. MOTHER'S MAIDEN NAME Mary Marll							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) Yes War II			16. SOCIAL SECURITY NO.			17. INFORMANT Edith Goetzke 1813 BrairCliff Road			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion												
420.1 DUE TO Sudden												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE Charles F O'Donnell		DATE SIGNED 9/24/60										
EXAMINER'S NAME (Type) Charles F O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 27, 1960 Baltimore National Cemetery		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) Baltimore Md		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE LEO G. COOK 1701 PATTERSON RK. AVE.		ADDRESS		24a. REC'D BY REGISTRAR Com. Frederick Rd Balto Md		24b. REGISTRAR'S SIGNATURE Charles F. Trahan						
				DATE SEP 28 '60								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9996

09953

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the funeral director, may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the death certificate and given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street, Maryland	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Street, Maryland	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Columbus	Last Graybeal
4. DATE OF DEATH September 1 1960	Month	Day	Year
S. SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1888
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) ASH Co North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown WINTON GRAYBEAL		14. MOTHER'S MAIDEN NAME Unknown AMANDA JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) un/know		16. SOCIAL SECURITY NO 214-18-3620 Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH			
4-3-5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Generalized arteriosclerosis	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 30 1960 to Sept. 1 1960, that (I) (we) last saw the deceased alive on Sept. 1 1960, and that death occurred at p. M., from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler, M. D.		22b. DATE SIGNED 9-2-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/60	
23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Garden		23d. LOCATION (City, town, or county) Bel Air Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles C. Katz		25a. REC'D BY REGISTRAR DATE SEP 6 '60	
ADDRESS Ferrattsville Md		25b. REGISTRAR'S SIGNATURE John E. K.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be noted and by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

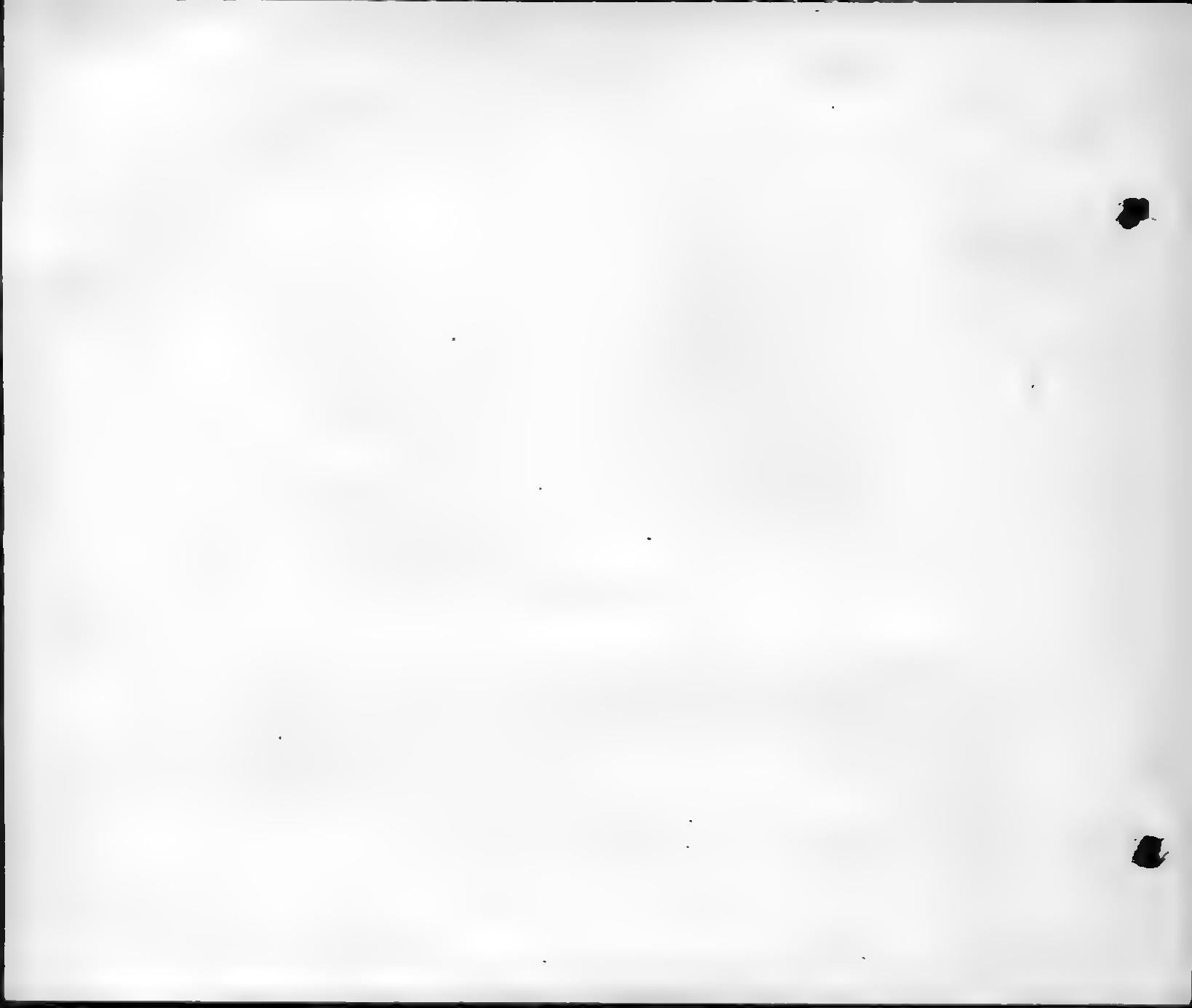
CERTIFICATE OF DEATH

09954

9997

Item 6 Form 673 10-14-60 et

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Maryland b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Towson						Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		110 E. Susquehanna Avenue		d. STREET ADDRESS		110 E. Susquehanna Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Joseph		Thom	as	Grevell	Sept.	28,		1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours	10. ADDRESS	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 27, 1877	82	Months	Days	110 E. Susquehanna Ave.	Towson, Md.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired - Bartender		Retail Bar		Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Thomas Grevell		Mary Alice Sternor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
No		None		Johanna R. Grevell		110 E. Susquehanna Ave. Towson 4, Md.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		myocardial infarction					
120.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO		coronary occlusion					
		(c) DUE TO		ASCV disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour o. m. - p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above									
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
Daniel Wilson		203 E. Beech Ave., Towson							
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county)		(State)	
Burial		Oct. 3, 1960		Mt. Marie Cemetery		Towson, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John Burns Son, Towson, Md.				Oct 4 60		Arthur S. Burns			
VR A15 (4) 1SM 9/59									



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

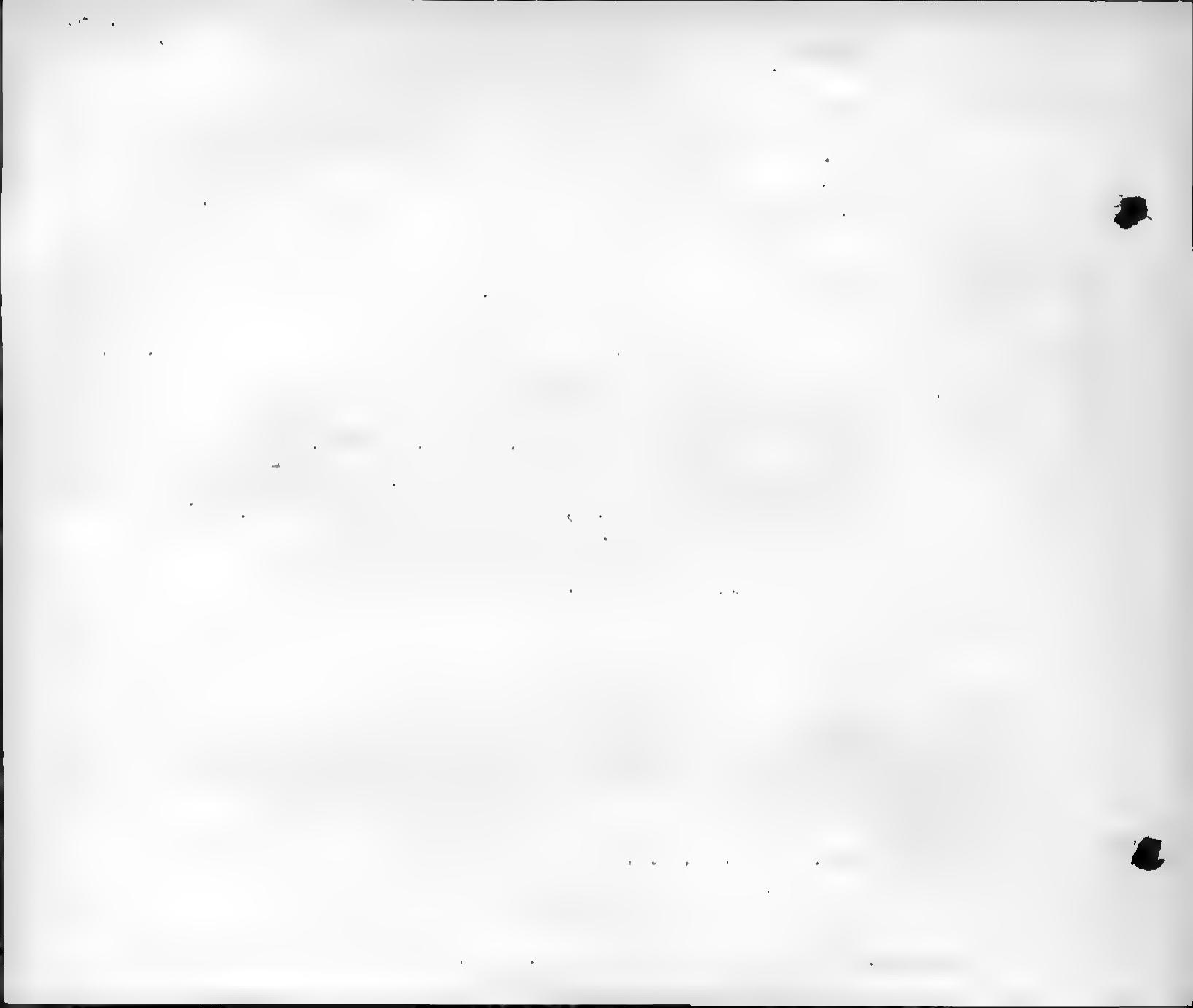
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09955

9998

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 31 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (23)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2563 W. BALTIMORE STREET				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH		Middle -----	Last GUINYARD	4. DATE DEATH	Month SEPTEMBER	Day 2	Year 1960					
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 12, 1932	9. AGE (In years lost birthday) 28 yrs.	IF UNDER 1 YEAR Months 28		IF UNDER 24 HRS Hours 00				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STAMPER			10b. KIND OF BUSINESS OR INDUSTRY STEEL CO.			11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA					12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME REBECCA GUINYARD			Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO KOREAN		17. INFORMANT CLIN. REC. VET. ADM. HOSP. BALTO 18, MD FT HOWARD DIV.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHONDROSARCOMA OF THE LEFT MAXILLA WITH EXTENSION INTO THE ANTRUM, SOFT PART OF THE FACT AND FRONTAL REGION, LEFT. (INTERVAL BETWEEN ONSET AND DEATH 1 YEAR)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) XNXX METASTATIC CHONDROSARCOMA TO BOTH LUNGS AND LYMPH GLAND. (INTERVAL BETWEEN ONSET AND DEATH 1 YEAR)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
CACHEXIA - 2 MONTHS													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (X) (this hospital) attended the deceased from August 2, 1960 , to September 21, 1960 , that (X) (we) last saw the deceased alive on September 20, 1960 , and that death occurred at 5:00A M. from the causes and on the date stated above.													
22a. SIGNATURE Frederick S. Donaldson		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/2/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAR Balto 18, Md., Ft Howard Division											
23a. BUR AL, CREMAT ON, REMOVE A. (Specify) Burial		23b. DATE THEREOF 9/6/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore		(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto.		ADDRESS 17, Md.		25a. REC'D BY REGISTRAR DATE SEP 8 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline							



TO HOSPITAL may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9999

09956

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) o STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN lb 41 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (11)		d. STREET ADDRESS 3630 Keswick Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RAYMOND	Middle R.	Last HALL	4. DATE OF DEATH	Month September	Day 28	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1897	9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lee Hall		14. MOTHER'S MAIDEN NAME Anna Butler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-18-8676		17. INFORMANT Address Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIV.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 145 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EPIDERMOID CARCINOMA OF POSTERIOR TONSILLAR PILLAR (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (F) (this hospital) attended the deceased from August 18 1960 to September 28, 1960 , that (P) (we) last saw the deceased alive on Sept. 28 1960 , and that death occurred at 4:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE 9/28/60
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-1-60		23c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove Cemetery		23d. LOCATION (City, town, or county) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth		ADDRESS 3615-17 Chestnut Ave. Balto		25a. REC'D BY REGISTRAR SEP 30 '60		25b. REGISTRAR'S SIGNATURE John E. Kline	
VR A15 (4) 15M 9/59							

500

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

99.38

CERTIFICATE OF DEATH

Reg. Dist. No.

69957

1. PLACE OF DEATH a. COUNTY <i>BALTIMORE</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>BALTO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Du. - DALEK</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUN VALLEY</i>		d. STREET ADDRESS <i>122 WALNUT AVE.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>122 WALNUT AVE.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ALICE</i>	Middle <i>JANE</i>	Last <i>HAMILTON</i>	4. DATE OF DEATH <i>SEPT.</i>	Month <i>1</i>	Day <i>1</i>	Year <i>1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-24-1905</i>	9. AGE (In years lost birthday) <i>55 yrs</i>	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS. Days <i>5</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>PERSON Co., N.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>STEVEN HARRIS</i>		14. MOTHER'S MAIDEN NAME <i>NICIE CARRINGTON</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>CARTEZ GARNETT - 122 WALNUT AVE</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>725X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>Diphtheria pneumonia</i>		DUE TO <i>Arthritis & hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Aug 21-60 to Sept 1-60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>-</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>		20f. (City or town) (County) (State) <i>-</i>	
21. I certify that I attended the deceased from <i>Aug 21-60</i> to <i>Sept 1-60</i> , that I last saw the deceased alive on <i>Sept 1-60</i> , 19 <i>60</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above				ADDRESS (Street, city or town, state) <i>107 n. Main St.</i>		DATE SIGNED <i>Baltimore 22 Md.</i>	
ACTUAL SIGNATURE <i>J.H. Thomas</i>		PHYSICIAN'S NAME (Type) <i>D.H. Thomas</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 4, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Peters</i>		22d. LOCATION (City, town, or county) (State) <i>Scy. To Boston, V.A.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charlie R. Lewis</i>		ADDRESS <i>802 Mad. Ave. Baltimore</i>		24a. REC'D BY REGISTRAR <i>DATE SEP 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles R. Lewis</i>	

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09958

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>		c. LENGTH OF STAY IN lb <u>21 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>2234 Guilford Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>OLIE</u>	Middle <u>J.</u>	Last <u>HAMILIN</u>	4. DATE OF DEATH <u>JUN 7, 1897 63 yrs.</u>	Month <u>September</u>	Day <u>13</u>	Year <u>1960</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 7, 1897 63 yrs.</u>	9. AGE (In years last birthday) Months <u>0</u>	IF UNDER 1 YEAR Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>		11. BIRTHPLACE (State or foreign country) <u>Dendron, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Hamlin</u>				14. MOTHER'S MAIDEN NAME <u>Rose Stringfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>213-01-5300</u>		17. INFORMANT <u>Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>XX</u> RUPTURED ESOPHAGEAL VARIX WITH MASSIVE HEMORRHAGE IN THE STOMACH INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>XX</u> THROMBOSIS OF THE MIDDLE CEREBRAL ARTERY (c) <u>XX</u> MARKED CEREBRAL ARTERIOSCLEROSIS UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(he)</u> attended the deceased from <u>August 23, 1960</u> to <u>September 13, 1960</u> . That <u>(we)</u> lost saw the deceased alive on <u>Sept. 13, 1960</u> , and that death occurred at <u>9:30 p.m.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Frederick S. Donaldson</u>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u>		22d. ADDRESS <u>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</u>					
23a. BURIAL CREMATION OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/13/60</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Baltimore National</u>		23d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Locks Funeral Home</u>				ADDRESS <u>1304 N. Central Ave. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE SEP 19 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

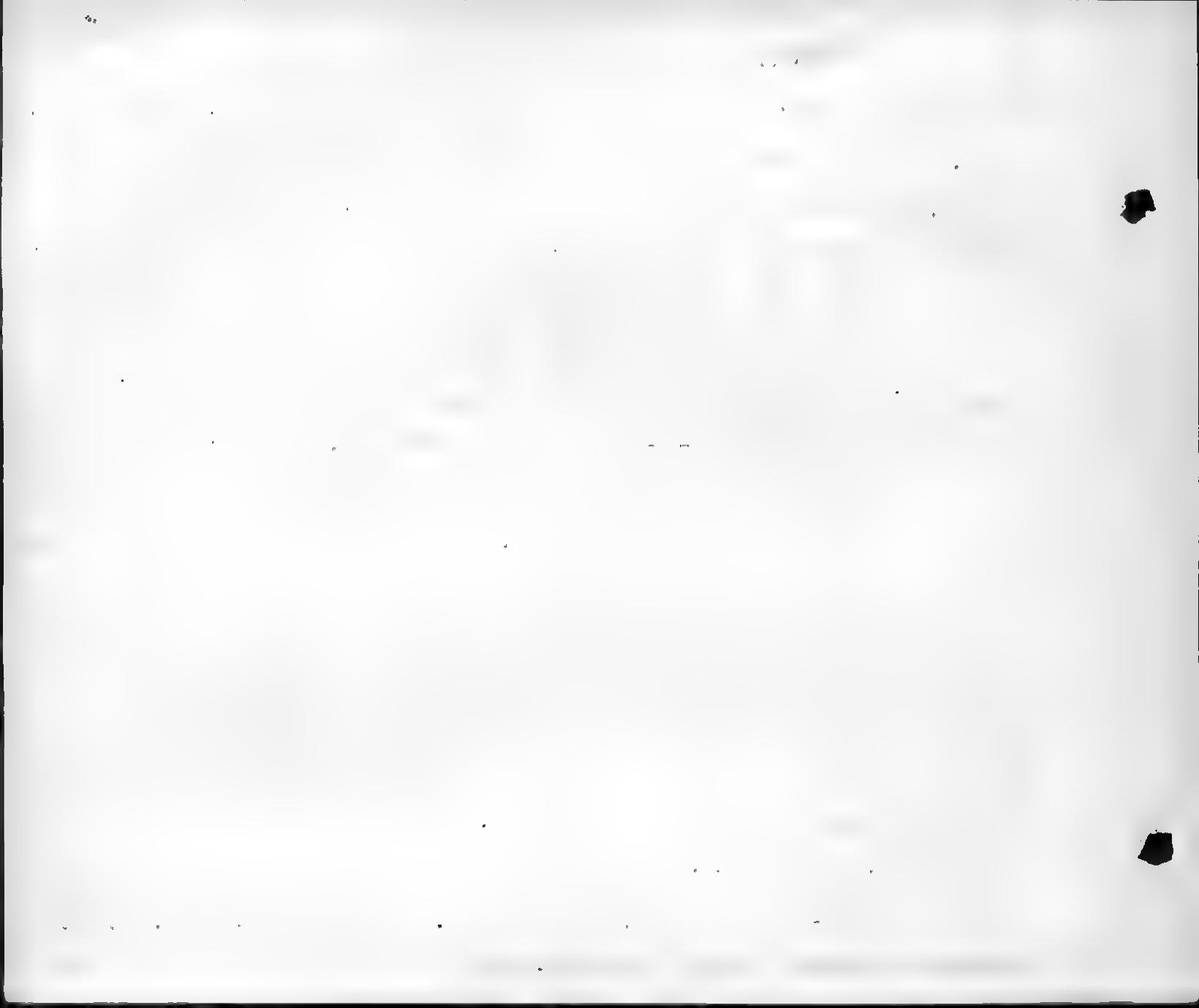
10001

CERTIFICATE OF DEATH

09959

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mr. Wilson State Hospital		d. STREET ADDRESS 4115 Lime Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID		First C	Middle E	Last L	4. DATE OF DEATH Sept. 29 1960	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.28.1887	9. AGE (in years last birthday) 73 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	Days 0	Year 0	
10a. LEGAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ABRAHAM HARE		14. MOTHER'S MAIDEN NAME REBECCA CRAUNER		INFORMANT		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-32-1456		17. HOSPITAL RECORDS Hospital Records, Mt. Wilson, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH over 2 yrs					
(b) DUE TO Arteriosclerosis, generalized		(c)		INTERVAL BETWEEN ONSET AND DEATH over 5 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Moderately advanced pulmonary tuberculosis									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) from the causes and on the date stated above.		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mt. Wilson, Maryland	
21. I certify that I attended the deceased from 5.26.1960 to 9.29.1960 that I last saw the deceased alive on 9.29.1960 and that death occurred at 11:48 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		DATE SIGNED 9.29.1960					
ACTUAL SIGNATURE Wm. Newcomer		PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-1960		22c. NAME OF CEMETERY OR CREMATORIAL Sr. Michael's Luth.	22d. LOCATION (City, town, or county) Perry Hall, Baltimore Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence Funeral Home 740 Belair Rd		ADDRESS Lawrence Funeral Home 740 Belair Rd		24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE John S. Evans			



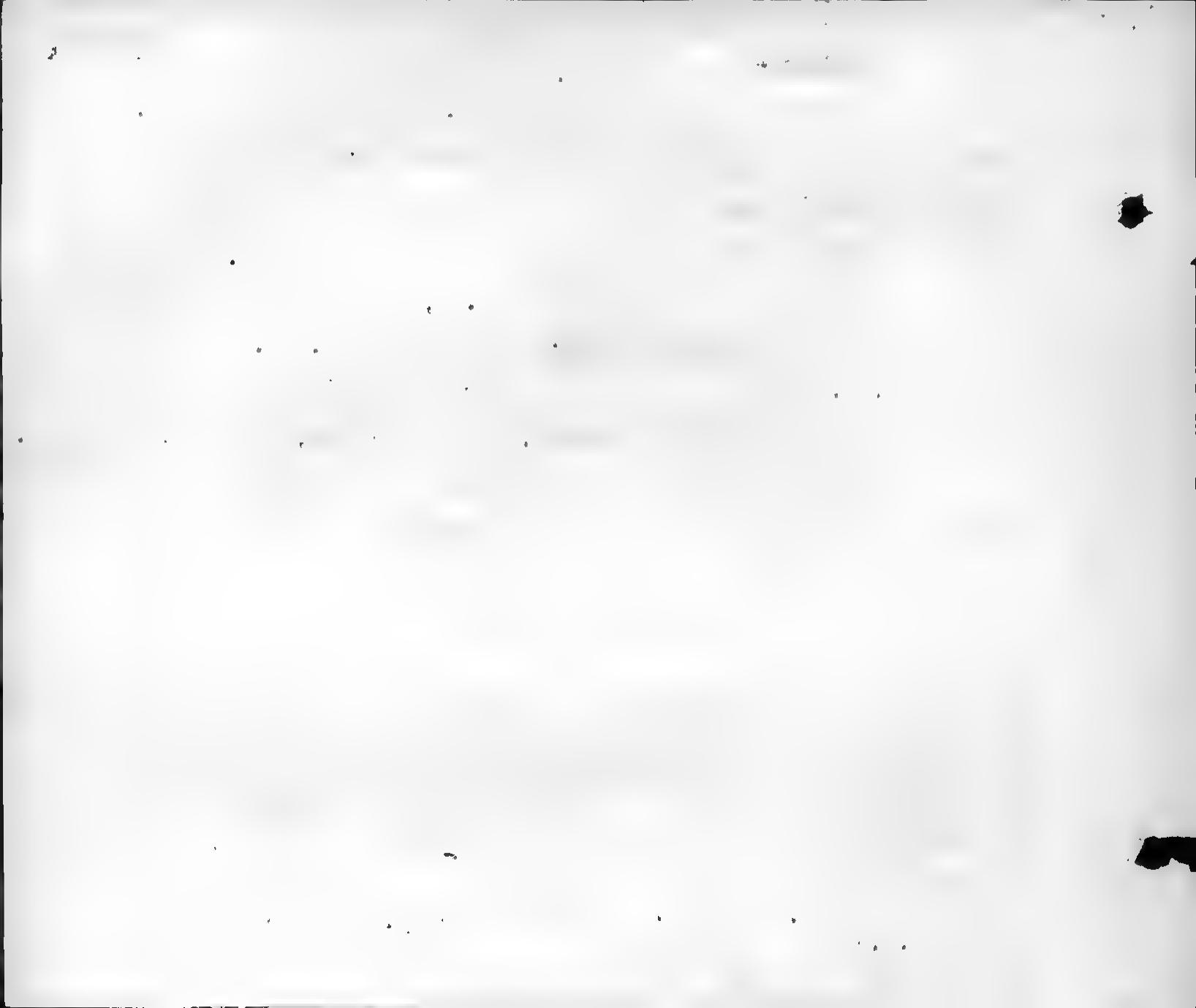
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10002 1960

1. PLACE OF DEATH a. COUNTY Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	b. COUNTY Balto.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b RURAL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6133 Regent Park Road	d. STREET ADDRESS 6133 Regent Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) William Glenn Harne	First William	Middle Glenn	Last Harne	4. DATE OF DEATH Sept. 2/60	Month Sept.	Day 2	Year 1960		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1897	9. AGE (in years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY University Md. Medical School		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William D. L. Harne		14. MOTHER'S MAIDEN NAME Katherine Wise							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		220 36 5254		Mrs. Edna Mae Harne		6133 Regent Park Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis INTERVAL BETWEEN DUE TO Liver ONSET AND DEATH Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of the Urinary Bladder 6 yrs DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pylonephritis 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/27/60 to 9/2/60 that (I) (we) last saw the deceased alive on 9/2/60 , and that death occurred at 7 PM , from the causes and on the date stated above									
22a. SIGNATURE William G. Edmond		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 2/60		
22c. PHYSICIAN'S NAME (Type) William G. Edmond		22d. ADDRESS 5018 Balt. National Pike							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 6/60		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Church Cemetery		23d. LOCATION (City, town, or county) Garfield, Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Mitzke F.D. #101 Edmondson Ave		ADDRESS		25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE Arthur J. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10003

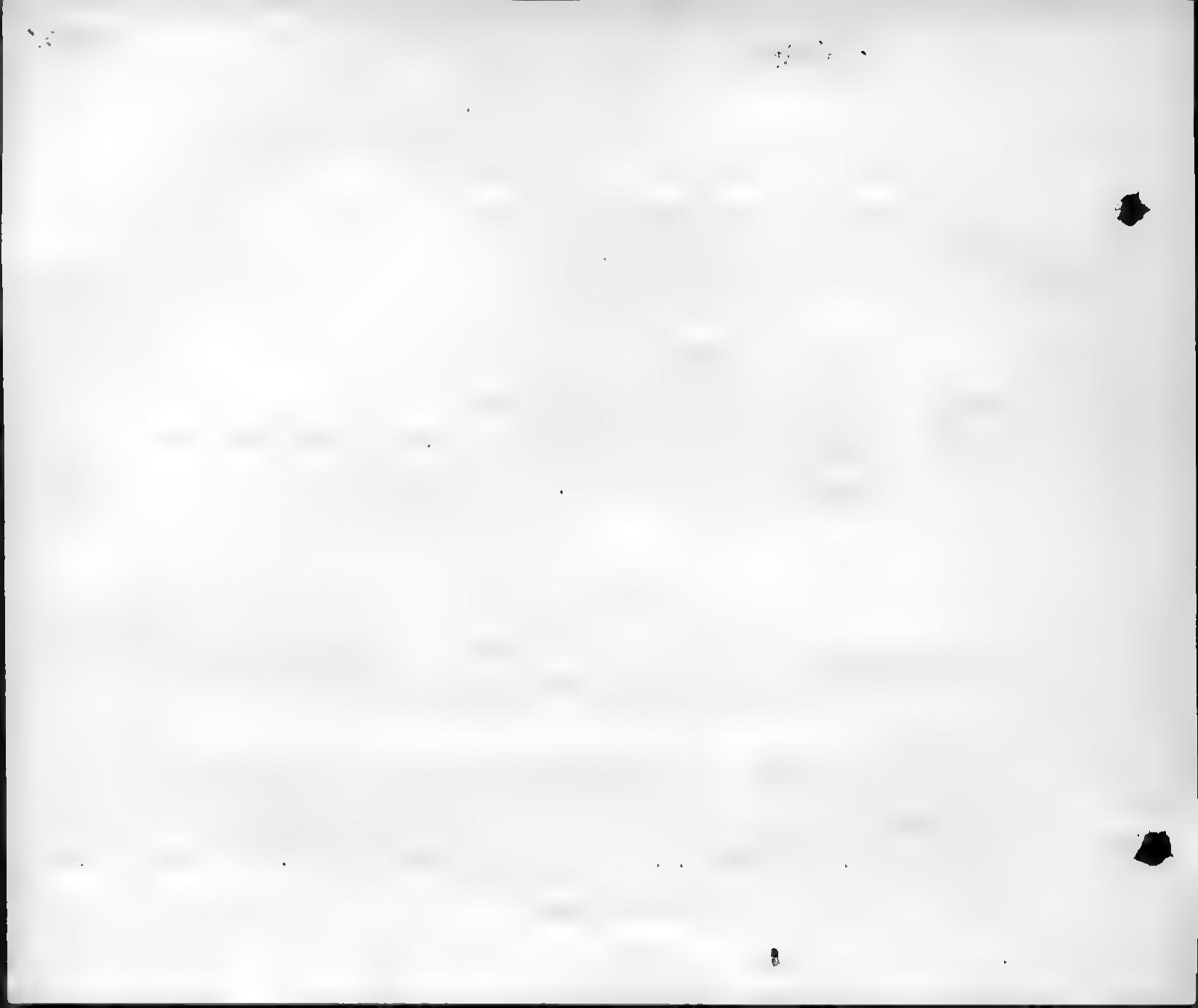
CERTIFICATE OF DEATH

69961

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS RD. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LUTHER	Middle R.	Last HARNER	4. DATE OF DEATH	Month September	Day 13	Year 19 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1894	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Harner				14. MOTHER'S MAIDEN NAME Mary C. MN: Ott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-12-2070		17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS							
420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (b)					
		DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 11, 1960, to Sept. 13, 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 13, 1960, and that death occurred at A. M., from the causes and on the date stated above							
22a. SIGNATURE <i>Frederick S. Donaldson</i>		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 9/13/60
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		23d. LOCATION (City, town, or county) Harney Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland		ADDRESS		25a. REC'D BY REGISTRAR SEP 15 '60		25b. REG STRAIGHT'S SIGNATURE <i>Charles S. Straub</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reamed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09962

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS formerly of Wyman Pk. Apts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines - 16 Fusting Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BESSIE	Middle B.	Last HAWBAKER	4. DATE OF DEATH	Month Sept.	Day 18,	Year 19 60
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1878	9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Secretary		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George B. Hawbaker				14. MOTHER'S MAIDEN NAME Clarissa E. Ziegler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. A-21-6182		17. INFLUIMENT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Extracerebral Vascular accident. INTERVAL BETWEEN ONSET AND DEATH 443X 1 hour.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Cerebrovascular disease & previous episode, few months		(c) Hypertension. C.V.D.		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 23, 1960 , to Sep 18, 1960 , that I last saw the deceased alive on Sep 18, 1960 , and that death occurred at 11:30 M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Bernard J. Cohen M.D.							
PHYSICIAN'S NAME (Type) Bernard J. Cohen, M.D. 3501 St. Paul St., Balto. 18, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/60	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.	22d. LOCATION (City, town, or county) Green Castle, Pa.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thorne				24a. REC'D BY REGISTRAR DATE SEP 22 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Thorne		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

49963

CERTIFICATE OF DEATH

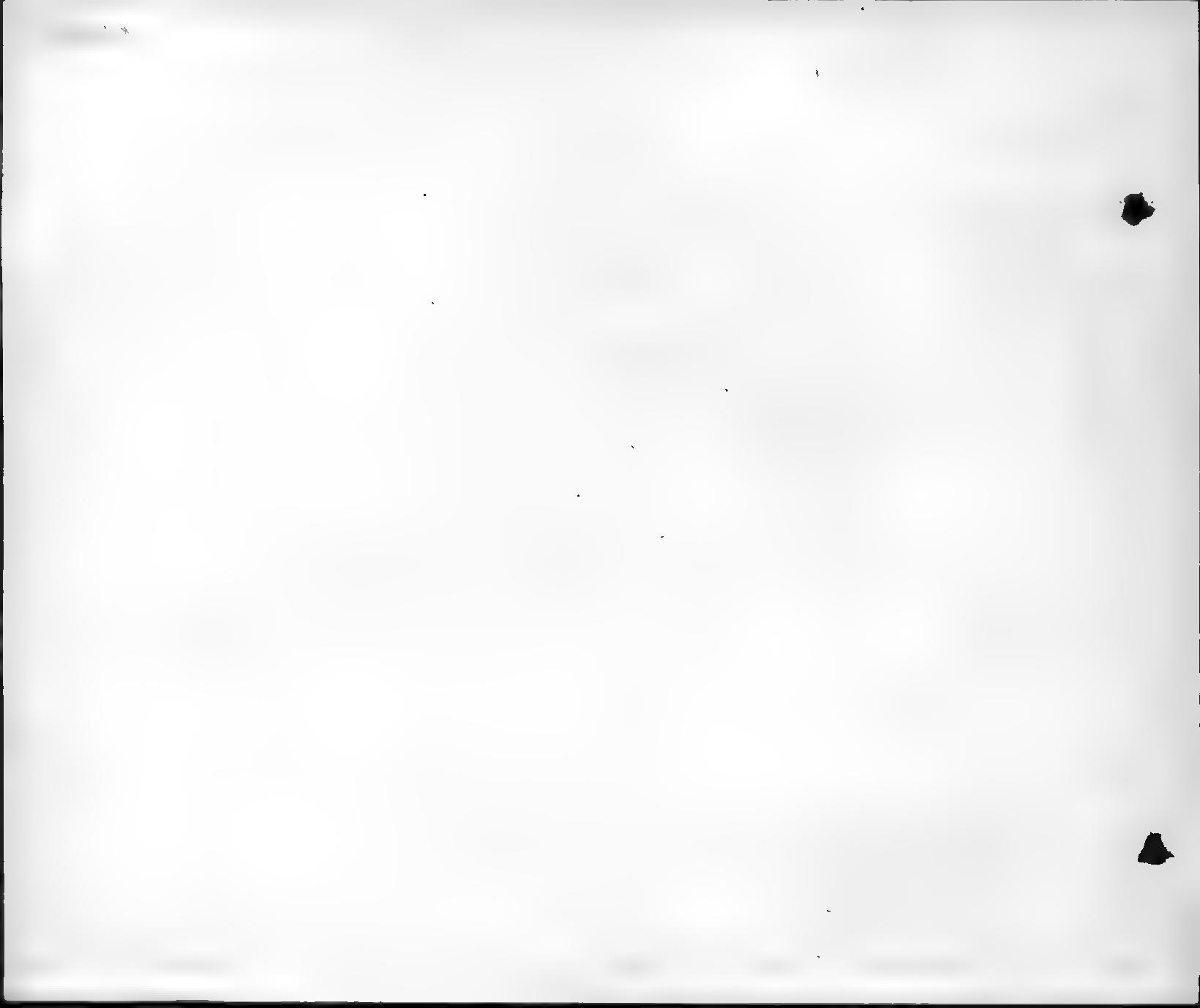
Reg. Dist. No.

10005

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)		o. STATE Maryland		to COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rosedale		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution)		1119 Chesaco Ave.				d. STREET ADDRESS		1119 Chesaco Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles Joseph Hersl		Middle		4. DATE OF DEATH		Sept. 16		Month Day Year 1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Machinist		Bethlehem Steel		Baltimore, Md.		USA.					
13. FATHER'S NAME		James Hersl		14. MOTHER'S MAIDEN NAME		CAROLINE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		W.W.I 212-09-6377		Elizabeth L. Hersl		1119 Chesaco Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
4 DUE TO CORONARY Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO H.C.N.D. (c)											
INTERVAL BETWEEN ONSET AND DEATH Unknown											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 7:00 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Joseph E. Schulte M.D.</i>		ADDRESS (Street, city or town, state) 8019 Plaza Rd., Balt. 6, Md.		DATE SIGNED 9/17/60							
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-20-60		22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip E. Crach</i>		ADDRESS 1211 Chesaco Ave.		24a. REC'D BY REGISTRAR SEP 20 '60		24b. REGISTRAR'S SIGNATURE <i>C. L. St. Louis</i>					

TO HOSPITAL may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09964

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. LENGTH OF STAY IN lb PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		d. STREET ADDRESS 2617 Hillcrest Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2617 Hillcrest Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Ellis		First	Middle	Last	4. DATE OF DEATH Hewitt	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 19, 1888	9. AGE (in years lost birthday) 71 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)		Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Hewitt		14. MOTHER'S MAIDEN NAME Elizabeth Meredith						
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-10-9497		INFORMANT Mrs. Bessie M. Hewitt	Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mo								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21. I certify that I attended the deceased from June , 19 60 , to Sept 3 , 19 60 that I last saw the deceased alive on Aug , 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R Donald Jandorf M.D. PHYSICIAN'S NAME (Type) R Donald Jandorf Balt. 14, Md								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/60		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Mem Park		22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK		ADDRESS 5305 HARFORD RD.		24a. REC'D BY REGISTRAR DATE SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9943

CERTIFICATE OF DEATH

09965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Baltimore</i>		b. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Arbutus</i>		c. LENGTH OF STAY IN 1b <i>36 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1259 Vogt Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>	
3. NAME OF DECEASED (Type or print) <i>Howard J. Hickman Sr.</i>		d. STREET ADDRESS <i>1259 Vogt Ave</i>	
First <i>Howard</i> Middle <i>J.</i> Last <i>Hickman Sr.</i>		4. DATE OF DEATH Month <i>September</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 31, 1906</i>	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) <i>54 yrs.</i>	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>	
13. FATHER'S NAME <i>Robert B. Hickman</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Randall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-03-1997</i>	
17. INFORMANT <i>Mrs. A. Thressen</i>		Address <i>1246 Graystone Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Melanoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years 3 mos.</i>	
DUE TO <i>Metastasis To Lungs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Metastasis To Lungs</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 16, 1958</i> to <i>Sept 19, 1960</i> that (I) (we) lost <i>saw the deceased alive on Sept 19, 1960</i> and that death occurred at <i>2 PM</i> , from the causes and on the date stated above		22b. DATE SIGNED <i>Sept 19, 1960</i>	
22c. SIGNATURE <i>James A. Donkers</i>		22d. ADDRESS <i>101 E. Preston St.</i>	
22e. PHYSICIAN'S NAME (Type) <i>James A. Donkers</i>		22f. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/24/60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>New Calvary Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Cimbros, Inc.</i>		25a. REC'D BY REGISTRAR ADDRESS <i>1325 Sulphur Spring Rd.</i> DATE SEP 22 '60	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09966

CERTIFICATE OF DEATH

10007

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mths6days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3520 Overview Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Fannie		First		Middle		Last Higger		4. DATE OF DEATH September 6 1960	Month Day Year		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1893		9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jacob Mitnick				14. MOTHER'S MAIDEN NAME Bessie Schriver							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-1869		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pneumonia									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Arteriosclerotic cardiovascular disease									
DUE TO (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 6 1960, and that death occurred at 1:15 p.m., to Sept. 6 1960, that (I) (we) last saw the deceased alive on Sept. 6 1960, and that death occurred at 1:15 p.m., from the causes and on the date stated above.											
22a. SIGNATURE <i>Stella Wachsler, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-6-60			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland									
23a. BURIAL/CREMATON. REMOVAL (Specify) Burial 9-7-60		23b. DATE THEREOF 9-7-60		23c. NAME OF CEMETERY OR CREMATORIUM United Hebrew		23d. LOCATION (City, town, or county) Baltimore		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Jr.</i>		ADDRESS 3100 Eastern Place		25a. REC'D BY REGISTRAR DATE SEP 7 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hause</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

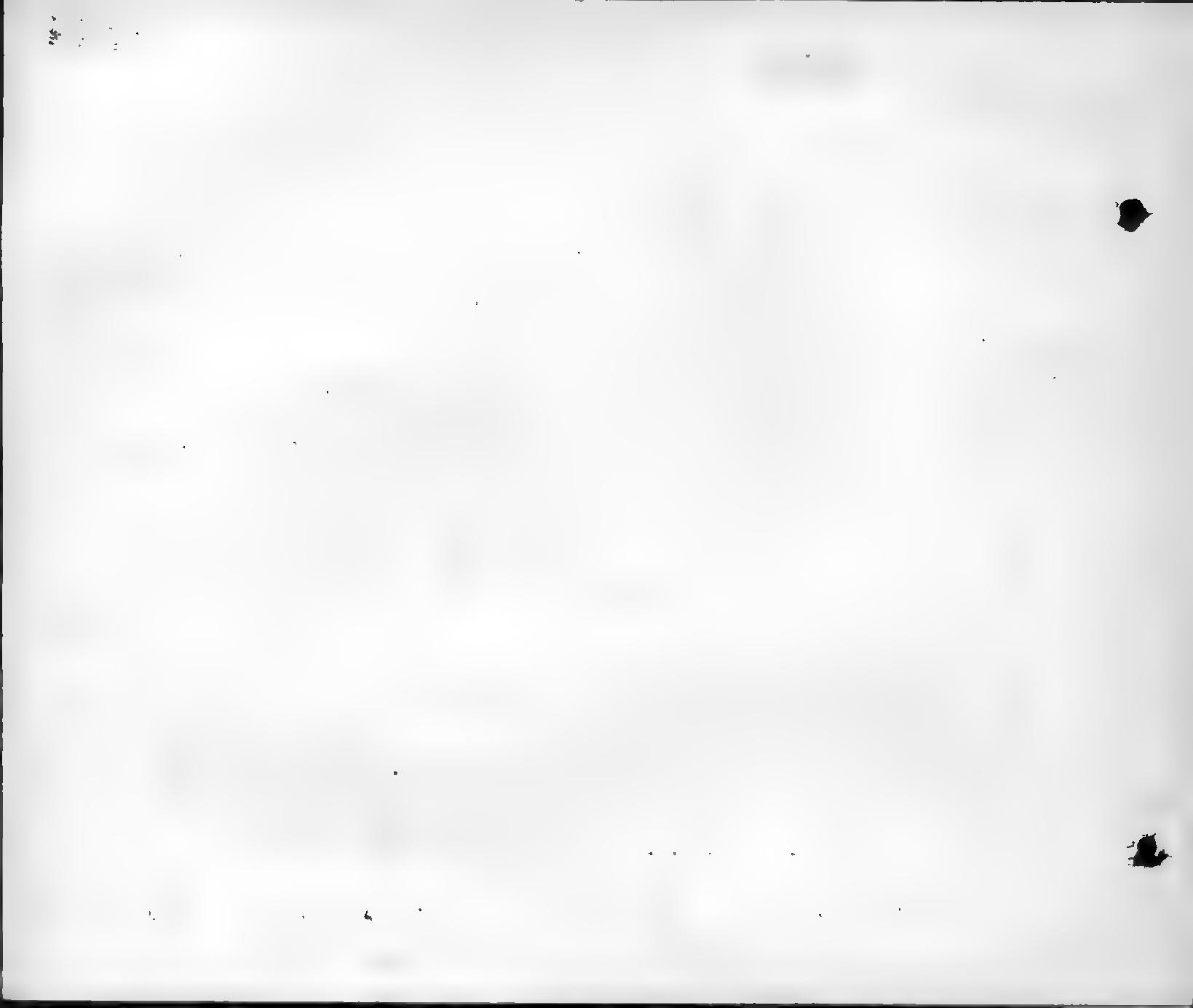
09967

9944

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
Baltimore		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY		
Halethorpe	38 yrs.	Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
1243 Francis Ave.	Halethorpe 51			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
Elsie		Hildebrand		
4. DATE OF DEATH	Month	Day	Year	
September 15			1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	January 29, 1882	
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
77 yrs	Housework	Maryland	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address		
James Thompson	Unknown	Margaret Tubbs 1243 Francis Ave.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
No		Margaret Tubbs		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				
156.1 DUE TO <i>Carcinomatous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Liver</i>				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on: <i>Sept. 10, 1960</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.				
22a. SIGNATURE <i>John C. Healy</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>Sept. 19, 1960</i>	
22c. PHYSICIAN'S NAME (Type) John C. Healy, M.D.		22d. ADDRESS 1305 Francis Avenue		
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/60	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCAT ON (City, town, or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ambrose, Inc. 1928 Lufkin Spring Rd.</i>		ADDRESS	25a. REC'D BY REGISTRAR Date SEP 19 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10008

CERTIFICATE OF DEATH

09968

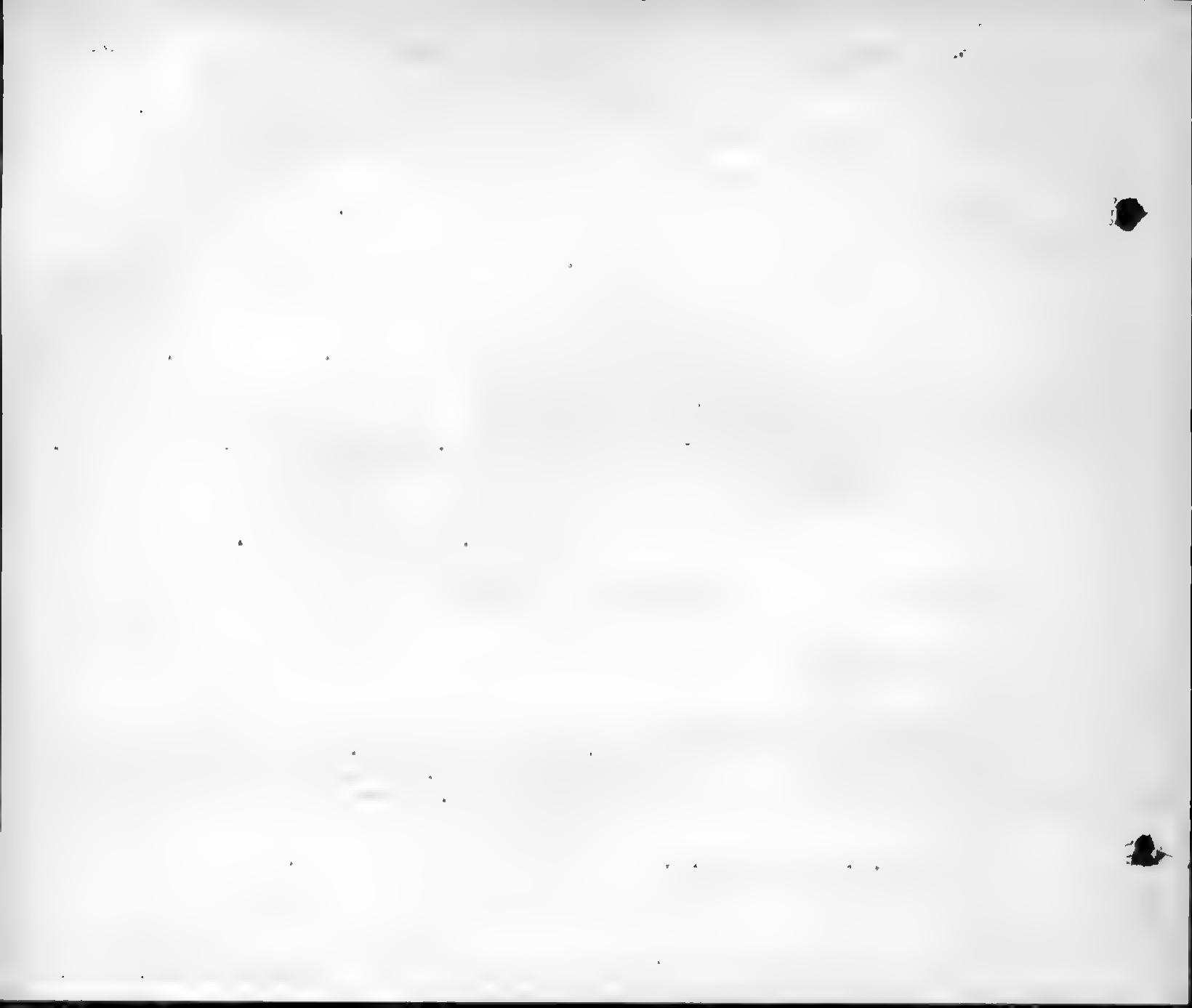
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Robert Ave.		d. STREET ADDRESS 13 Robert Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William James Hill Jr.		First	Middle	Last	4. DATE OF DEATH September 11, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 28, 1883	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Extractor		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME William J. Hill Sr.		14. MOTHER'S MAIDEN NAME Iuvinia Slaugther		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-03-1570		17. INFORMANT Lillian B. Johnson-712 Edmondson Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amputation of Rt Leg. (Gangrene) DUE TO Arteriosclerotic Heart Disease & (c) right Side Hemiplegia				I9 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				4 years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 57 Winters Lane		(County) Baltimore		(State) Maryland
21. I certify that I attended the deceased from Nov. 6th, 1957 , to Sept. 11th 1960 , that I last saw the deceased alive on Sept. 11th, 1960 , and that death occurred at 12.30 PM from the causes and on the date stated above ACTUAL SIGNATURE C.F. Maloney M.D. ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED 9/11/60								
PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.		Catonsville 28. Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter-3035 W. North Ave.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE John S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached and given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57



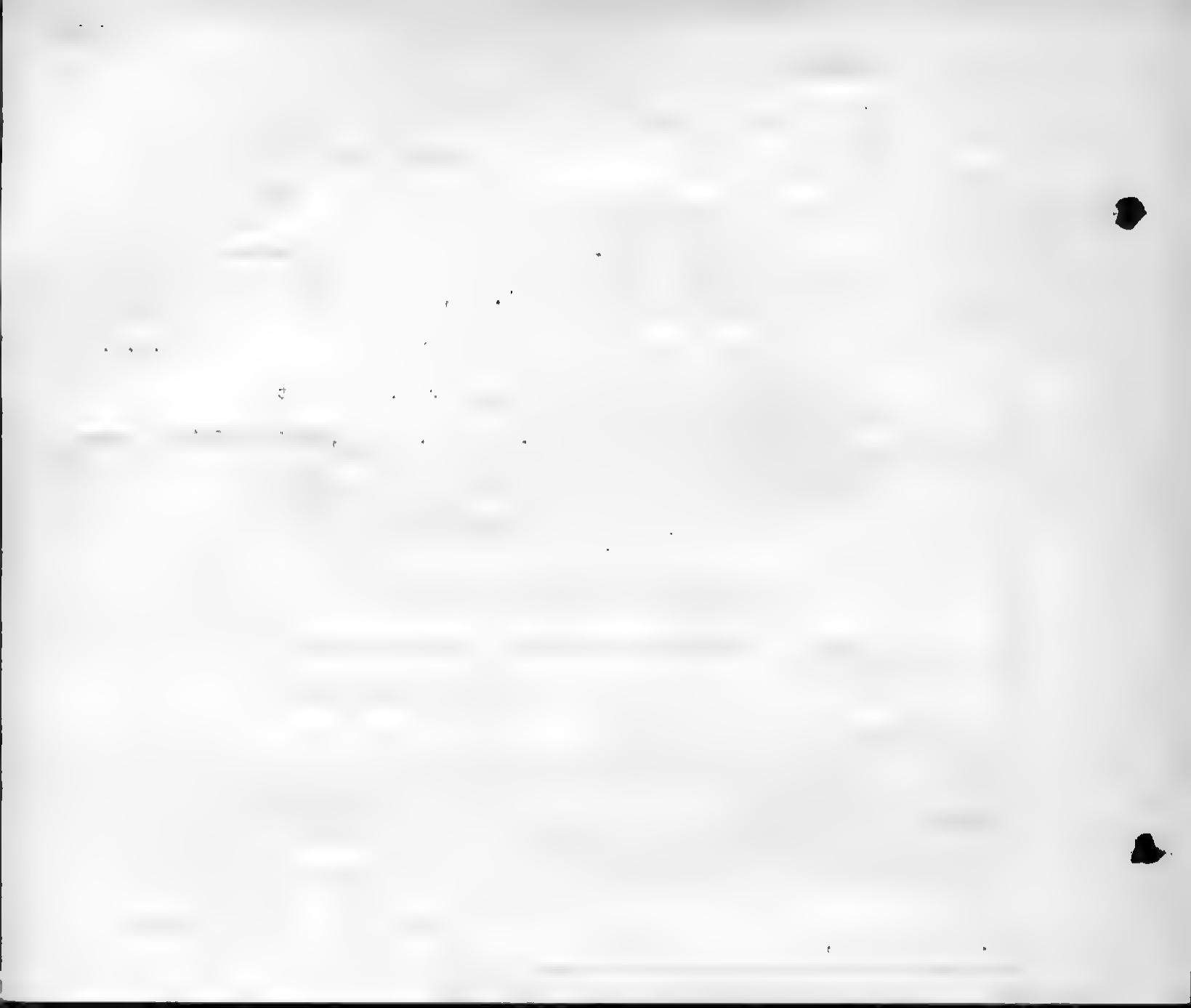
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09969

1. PLACE OF DEATH a. COUNTY Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3003 Woodside Avenue		d. STREET ADDRESS 3003 Woodside Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul C. Hohne	First Paul	Middle C.	Last Hohne
4. DATE OF DEATH September 18 1960	Month September	Day 18	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1887
		9. AGE (in years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Hohne		14. MOTHER'S MAIDEN NAME Albertina Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-3102	17. INFORMANT Address Mrs. Anna B. Hohne, 3003 Woodside Avenue
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		Breonsoma, colon with abdominal metastasis	
DUE TO 52		14 mos.	
DUE TO abdominal metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10, 1959 , to 9/19, 1960 , that I last saw the deceased alive on 9/18, 1960 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7101 Harford Rd.	
ACTUAL SIGNATURE Nathan Lanney		DATE SIGNED 9/20/60	
PHYSICIAN'S NAME (Type) Dr. Nathan Lanney			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-22-60	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, 6009 Harford Road		24a. REC'D BY REGISTRAR DATE SEP 21 '60	24b. REGISTRAR'S SIGNATURE John S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

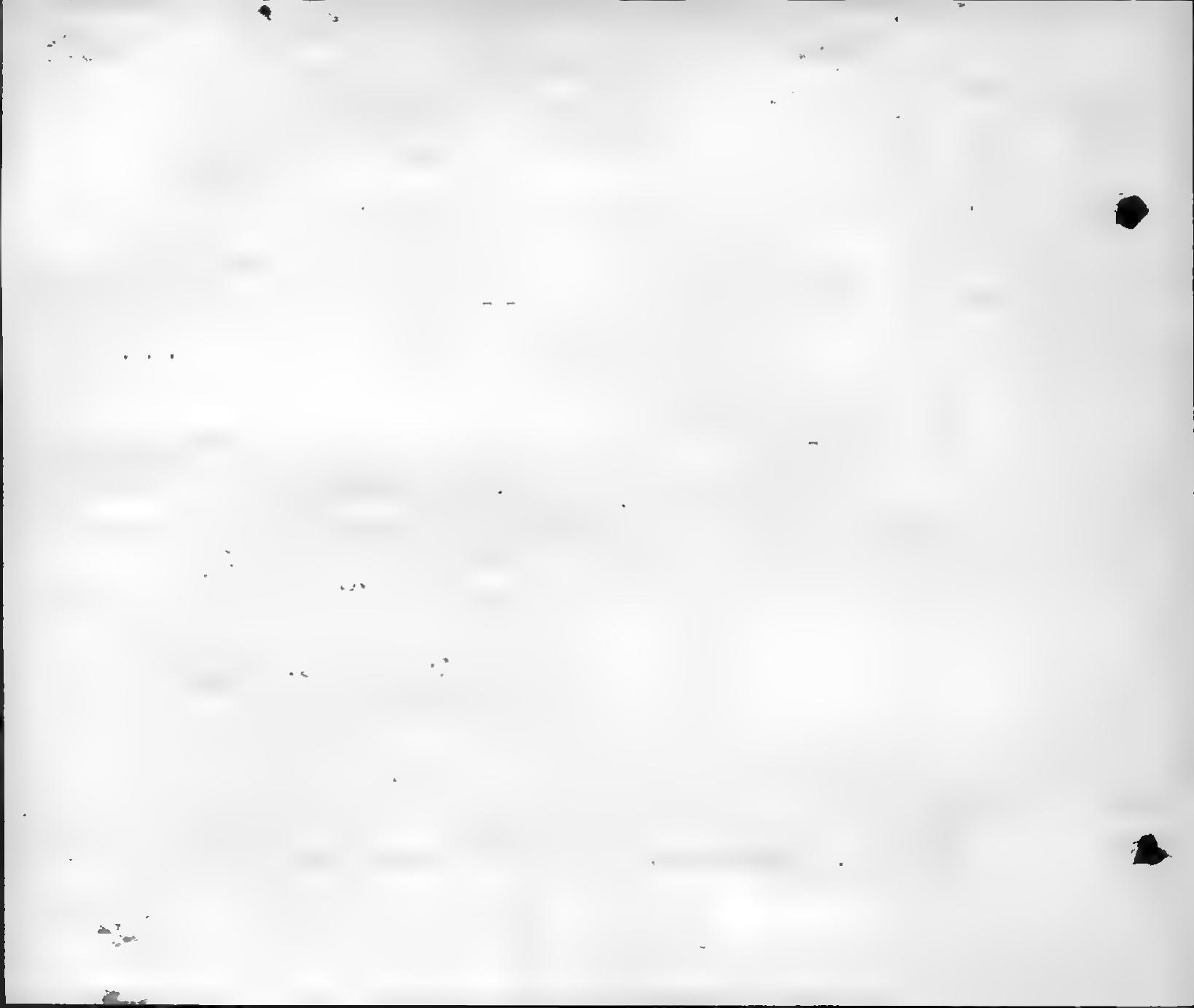
10010

Item 14

05970

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 52 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ANTON	Last HOLZHEIM
4. DATE OF DEATH		Month SEPTEMBER	Day 11
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
MALE		WHITE	B. DATE OF BIRTH 2-9-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TRANSFER COMPANY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HOLZHEIM		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO 212-03-7124	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) XXXXX IN OLD MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) XXXXX WITH METASTASIS TO LIVER (c)		UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>J</u> (this hospital) attended the deceased from July 21, 1960, to Sept. 11, 1960, that <u>J</u> (we) last saw the deceased alive on Sept. 11, 1960, and that death occurred 7:05 p. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S. Donaldson</u>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-15-60	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS MORELAND MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE John A Moran Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 15 '60	
		25b. REGISTRAR'S SIGNATURE C. J. Moran & Son	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

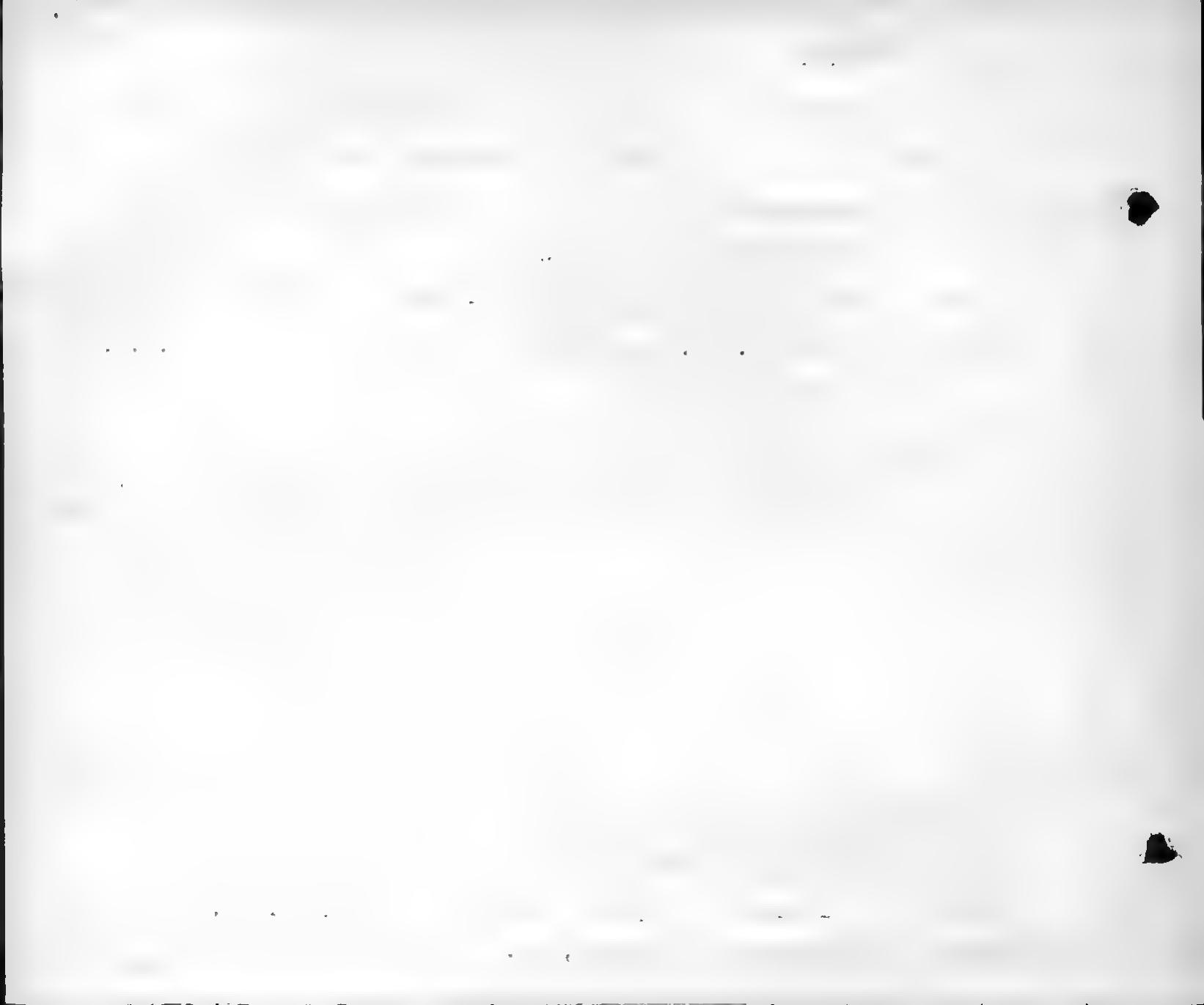
10011

CERTIFICATE OF DEATH

Reg. Dist. No.

09971

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE	
Baltimore MARYLAND		Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Lane		d. STREET ADDRESS Church Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		William	Walter Howard
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-14-1876
male	white		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Balto Co. Sanitation	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Richard Howard		14. MOTHER'S MAIDEN NAME Emma Perry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	INFORMANT Hilda Ford , Address above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC LIPIDIASCULPTURE DISEASE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JULY 1960</u> , to <u>SEPT 10, 1960</u> that I last saw the deceased alive on <u>SEPT 8, 1960</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Timonium Md.</u> DATE SIGNED <u>7-12-60</u>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Pillsbury</u> ADDRESS <u>Timonium Md.</u> DATE <u>7-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-13-60</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Jessop Methodist</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson4, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thorne</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09972

10012

CERTIFICATE OF DEATH

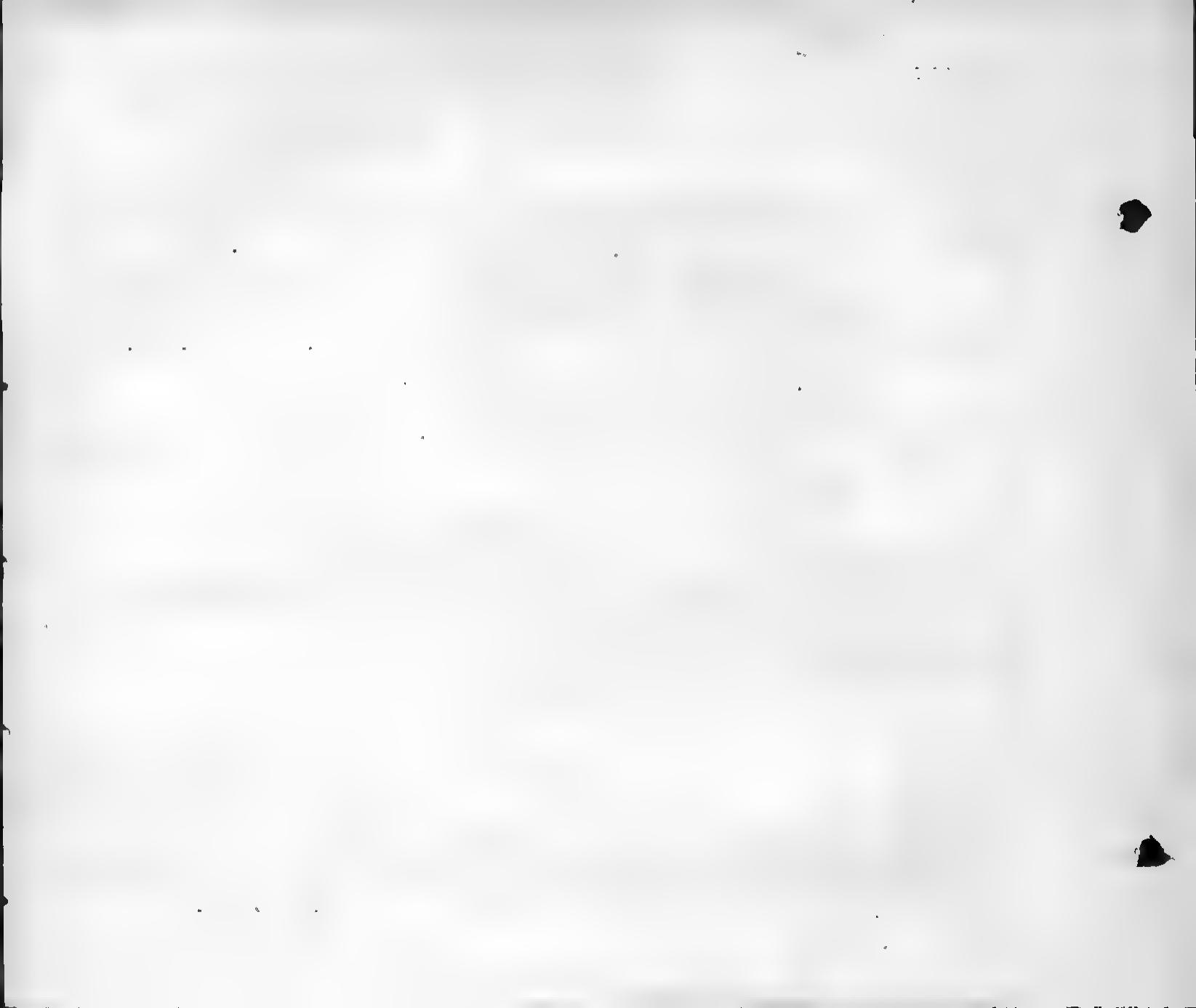
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillendale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillendale	
c. LENGTH OF STAY IN 1b 1		d. STREET ADDRESS 6809 Collingsdale Road Zone 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6809 Collingsdale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LENA	Middle M.	Last HUBBARD
4. DATE OF DEATH Sept. 9	Month Sept.	Day 9	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Zink		14. MOTHER'S MAIDEN NAME Mary Noellert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	
17. INFORMANT Catherine L. Carter, daughter, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
I SIX DUE TO Paroxysms of stomach INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last! (b) c generalized metastasis ONSET AND DEATH (c) to abdominal organs 6 months to 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 1956 to Sept 9 1960 that I last saw the deceased alive on Sept 9 1960 , and that death occurred at 3 p.m. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Smith		ADDRESS (Street, city or town, state) 6305 Lee Boulevard	
PHYSICIAN'S NAME (Type) Charles E. Schimunek		DATE SIGNED Sept 12 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/60	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home		ADDRESS 3331 Brahma Lane	
24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Charles E. Schimunek	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be registered by the hospital or attending physician

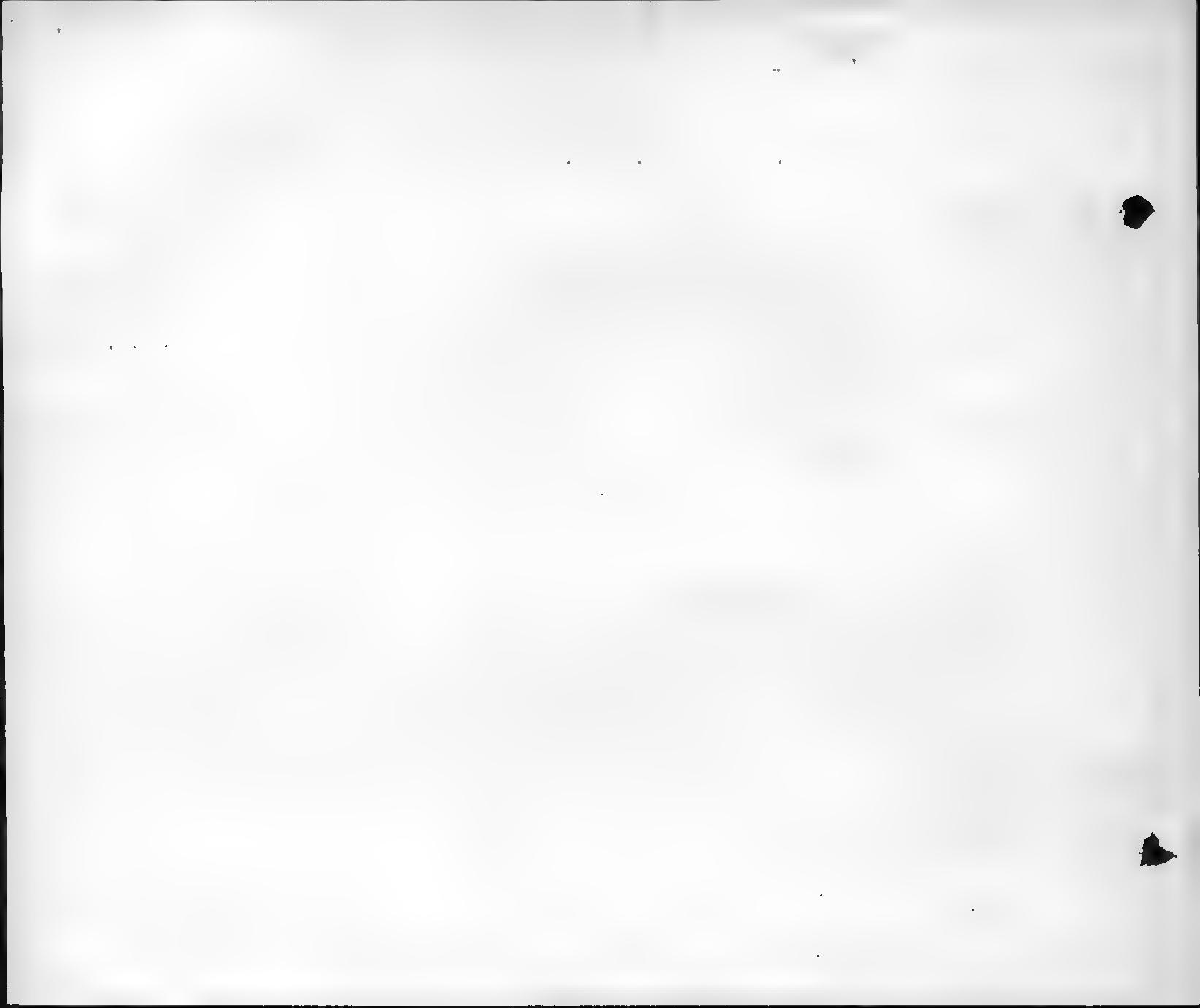
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19973

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY Baltimore		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Wings Mills Md.		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb 1 yr. 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS 6125 Fortview Way	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marcella	Middle Alice	Last Hunt
4. DATE OF DEATH	Month 9	Day 17	Year 1960
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-59
9. AGE (In years last birthday) 1 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Redmon Hunt		14. MOTHER'S MAIDEN NAME Grace Marcella Ruil Fritz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Rosewood Records	Address O'Wings Mills
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO	
344 X		Wynfylor capsules marked.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		complicated by aspiration of stomach content	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		3-9 1960 to 9-17 1960, that (I) (we) last saw the deceased alive on 9-17 1960, and that death occurred at 6:20 pm, from the causes and on the date stated above.	
22a. SIGNATURE <i>Jane W. Rieckert</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8-18-60
22c. PHYSICIAN'S NAME (Type) Jane W. Rieckert		22d. ADDRESS 4307 Mainfield Ave Baltimore	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial Sept 21/60		23c. NAME OF CEMETERY OR GREMATORIUM Rosewood Cem.	
23d. LOCATION (City, town, or county) Owings Mills Md		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE J F Elene Sons Restontown Md		25a. REC'D BY REGISTRAR DATE SEP 23 1960	25b. REGISTRAR'S SIGNATURE Cathy S. Kraus



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be read by the hospital or attending physician.

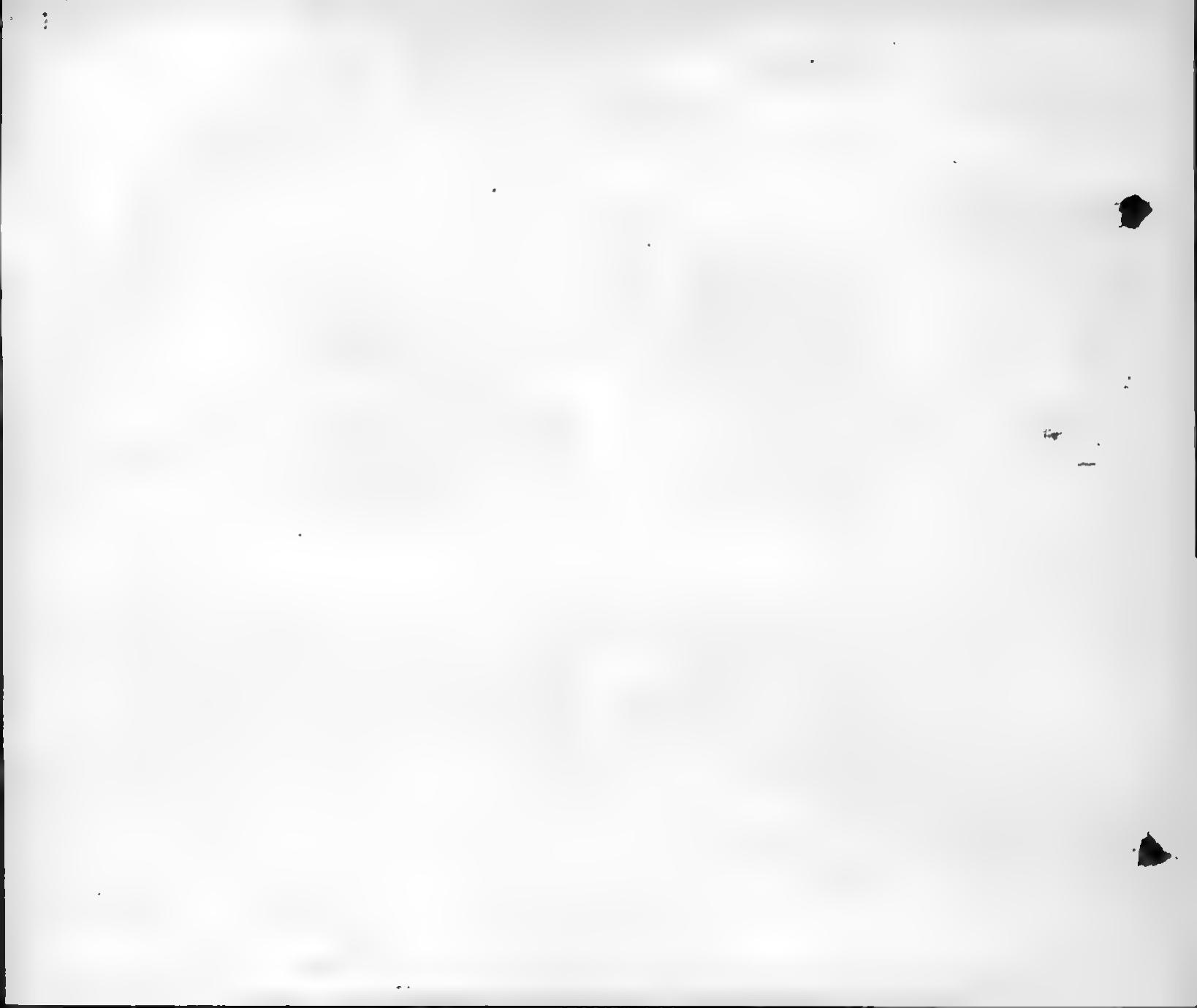
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09974

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. LENGTH OF STAY IN 1b <i>18 Mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gwynns Mills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hopkirk Nursing Home</i>				d. STREET ADDRESS <i>Ch. Henderson Lane</i>	
3. NAME OF DECEASED (Type or print) <i>DR. Henry Talbott Hutchins</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept 23 1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb 3 1877</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Medical Prof.</i>		11. BIRTHPLACE (State or foreign country) <i>Mass</i>	
13. FATHER'S NAME <i>George F. Hutchins</i>		14. MOTHER'S MAIDEN NAME <i>Edna Fairbanks</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or unknown) <i>yes WWI</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mrs H. Barry Wood Chettenden Lane</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterio - sclerosis, cerebral</i>					
DUE TO (b) <i></i>				5 years.	
DUE TO (c) <i></i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 1 1960</i> to <i>Sept 23 1960</i> that (I) (we) last saw the deceased alive on <i>Sep 22 1960</i> and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above				22b. DATE SIGNED	
22a. SIGNATURE <i>Palmer F. Williams</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>PALMER F. Williams</i>		22d. ADDRESS <i>Pikesville 8. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>9/24/60 London Park</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers 18728 Safety Rd.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>SEP 28 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>John E. Lewis</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09975

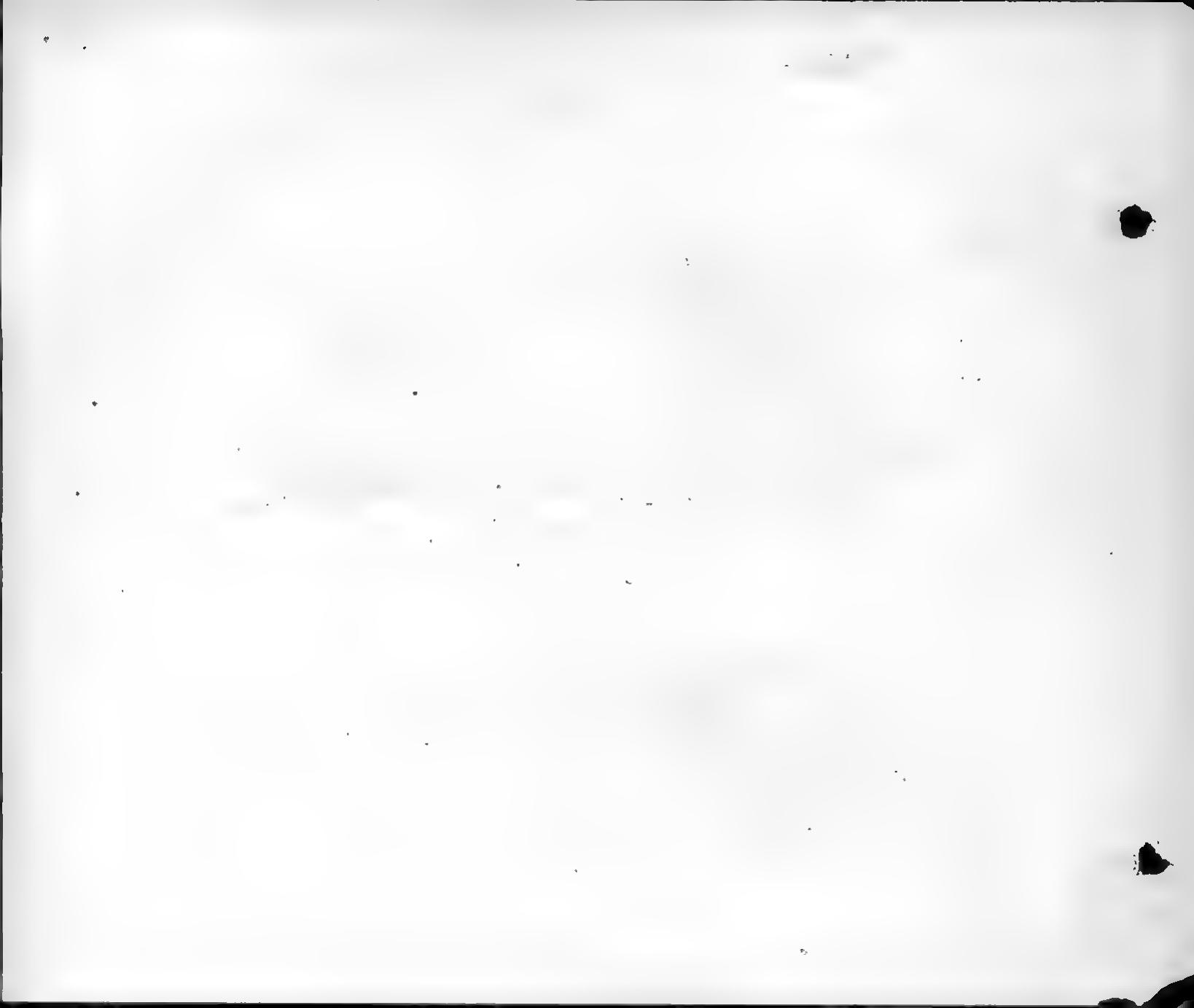
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10015		CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <i>Md</i>		If institution _____ Residence before admission _____ b. CITY OR TOWN <i>Baldwin</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>		c. LENGTH OF STAY IN 1b <i>65 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>		d. STREET ADDRESS <i>Sweetair Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>											
3. NAME OF DECEASED (Type or print) <i>Martha Ellen Gemicock</i>		First	Middle	Last	4 DATE OF DEATH <i>Sept 28 1960</i>	Month	Day	Year			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W.</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 9-1871</i>	9 AGE (In years last birthday) <i>89 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	Min. <i>0</i>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>-</i>		11 BIRTHPLACE (State or foreign country) <i>Fork Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John Hall</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Johnson</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>70-111111111</i>		INFORMANT <i>Mrs Clarence M. Harrison</i>		Address <i>Baldwin</i>					
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>593</i>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Hypertension</i>		C. DUE TO (c) <i>Debility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) <i>Fork</i>		20f. (City or town) <i>Fork</i>	(County) <i>Baltimore Co</i>				
20g. (State) <i>Md</i>						(State) <i>Md</i>					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, and that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Baldwin</i>		DATE SIGNED <i>Sept 26 1960</i>			
ACTUAL SIGNATURE <i>Walter M. Gannett</i>											
PHYSICIAN'S NAME (Type) <i>Walter M. Gannett</i>											
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 1-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fork</i>		22d. LOCATION (City, town or county) <i>Fork Baltimore Co Md</i>		(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter M. Gannett</i>		ADDRESS <i>11111 Sweetair Rd</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09976

1. PLACE OF DEATH COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] STATE Maryland		b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c LENGTH OF STAY IN 1b 48 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d STREET ADDRESS 210 Warfield Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle J.	Last JACKSON	4. DATE OF DEATH December 12, 1877	Month September	Day 12	Year 1960
S SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1877	9. AGE (in years last birthday) 82	IF UNDER 1 YEAR Months 82	F UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Gospel		11. BIRTHPLACE (State or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas J. Jackson		14. MOTHER'S MAIDEN NAME Lenita Hollis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes		16. SOCIAL SECURITY NO. 578-00-1128-02		17. INFORMANT Clin. Rec., Vet. Hospital, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE WITH METASTASES TO							
177 X XOGENOUS PELVIC BONES, LIVER AND LUNGS							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EMPHYSEMA OF LUNGS							
(c) XENEX CACHEXIA							
INTERVAL BETWEEN ONSET AND DEATH 4 YEARS							
UNKNOWN							
3 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19 60							
21. I certify that DRS (this hospital) attended the deceased from July 26 , 1960, to Sept. 12 , 1960, that W (we) last saw the deceased alive on Sept. 12 , 1960, and that death occurred at 6:30 A.M. from the causes and on the date stated above							
22a. SIGNATURE Frederick S. Donaldson							
22b. DATE 9/12/60							
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVED (Specify) Burial		23b. DATE THEREOF 9-16-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore	
(State) Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 2004 Orleans St. Balto. Md.							
ADDRESS				25a. REC'D. BY REGISTRAR SEP 22 1960		25b. REGISTRAR'S SIGNATURE Elroy O. Wilson	
DATE							
VR ATS (4) ISMA 9/59							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10017 CERTIFICATE OF DEATH										Reg. Dist. No. 09977		
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>					2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i>					If institution: Residence before admission b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>			c. LENGTH OF STAY IN 1b <i>56 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Powers Avenue</i>					d. STREET ADDRESS <i>Powers Avenue</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>George</i>	Middle <i>Henry</i>	Last <i>Johnson</i>	4. DATE OF DEATH <i>September 1, 1960</i>							
5. SEX <i>Male</i>		6. COLOR OF RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>31 August 1882</i>		9. AGE (in years from birth) <i>78 yrs</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Labour</i>			11. BIRTHPLACE (State or foreign country) <i>Sweet air Balto. Md</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>Samuel Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Ida Williams</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-26-2556A</i>			17. INFORMANT <i>Son</i>			Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Prostate</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)												
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19			Month August	Day 5	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cockeysville</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>August 1, 1960</i> to <i>September 1, 1960</i> , that I last saw the deceased alive on <i>September 1, 1960</i> , and that death occurred at <i>10:35 AM</i> , from the causes and on the date stated above										ADDRESS (Street, city or town, State) <i>Cockeysville, Md.</i> DATE SIGNED <i>September 1, 1960</i>		
ACTUAL SIGNATURE <i>Walter T. Kees</i>			M.D.									
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-4-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Basil Cemetery</i>			22d. LOCATION (City, town, or county) <i>Cockeysville,</i>			(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter T. Kees</i>			ADDRESS <i>50 W. Middle St.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

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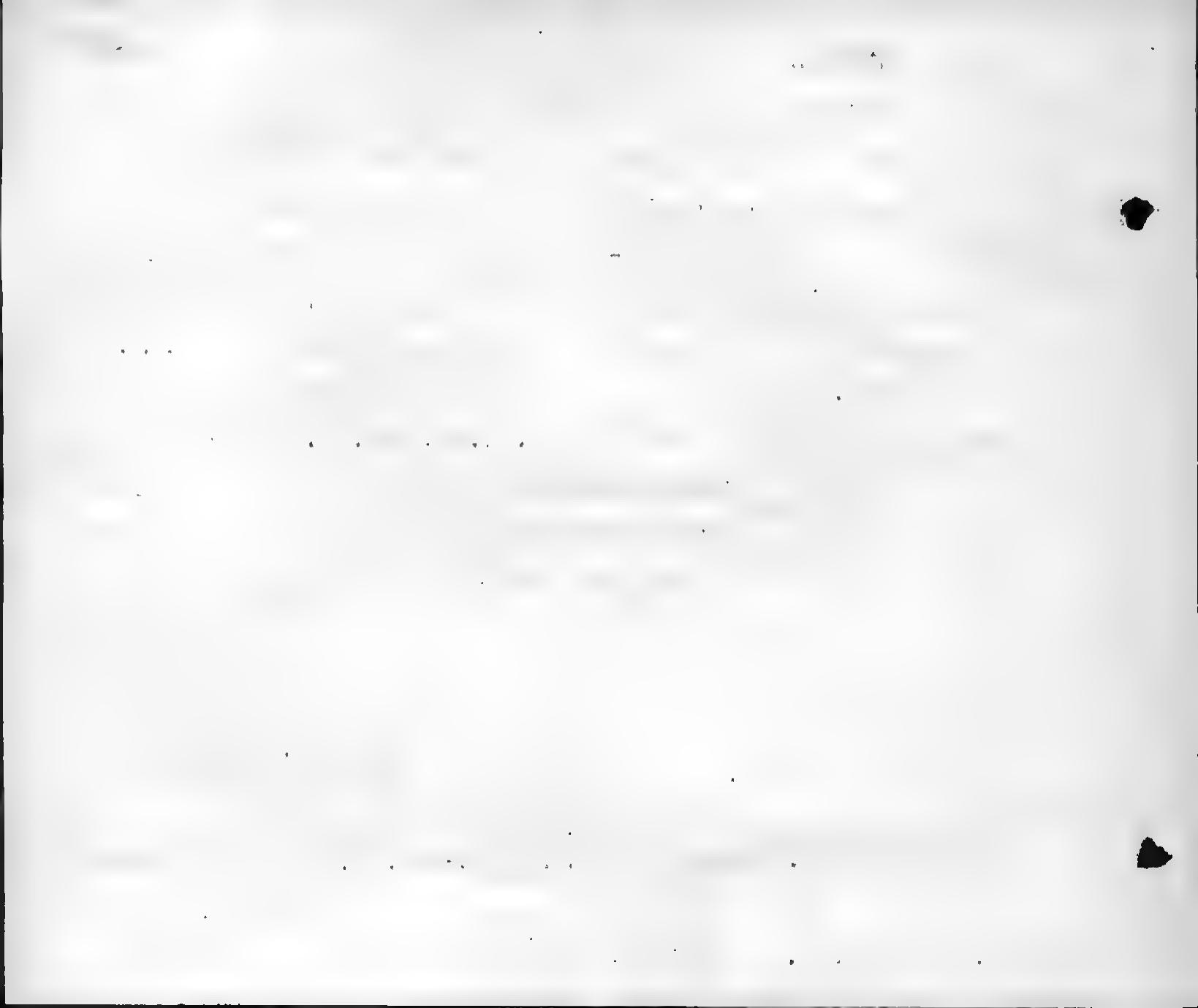
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09978

10018

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 28 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First OSCAR	Middle -	Last JOHNSON
4. DATE OF DEATH	Month SEPTEMBER	Day 3	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/83
9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? U.S.A.	11. BIRTHPLACE (State or foreign country) Mapleton, Michigan	12. FUNDER 1 YEAR Months 77 Days 0 Hours 0 Min 0 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY Automobile	14. MOTHER'S MAIDEN NAME Carolina Fredrickson	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO WV I & WW II	17. INFORMANT Clin.Rec.VAH,Balto. Md. Fort Howard Division	INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CHRONIC PANCREATITIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) CHRONIC PANCREATITIS			
PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) OLD MYOCARDIAL INFARCTION			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from August 6, 1960 to Sept. 3, 1960 , that I (we) last saw the deceased alive on Sept. 3, 1960 , and that death occurred at 7:15 AM the causes and on the date stated above			
22a. SIGNATURE <i>Joseph L. Reeves</i>		22b. DATE SIGNED 9/4/60	
22c. PHYSICIAN'S NAME Typ JOSEPH L. REEVES		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS XX	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		25a. REC'D BY REGISTRAR DATE SEP 7 '60	
		25b. REGISTRAR'S SIGNATURE Arthur J. Turner	



M TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be executed by the hospital or attending physician.

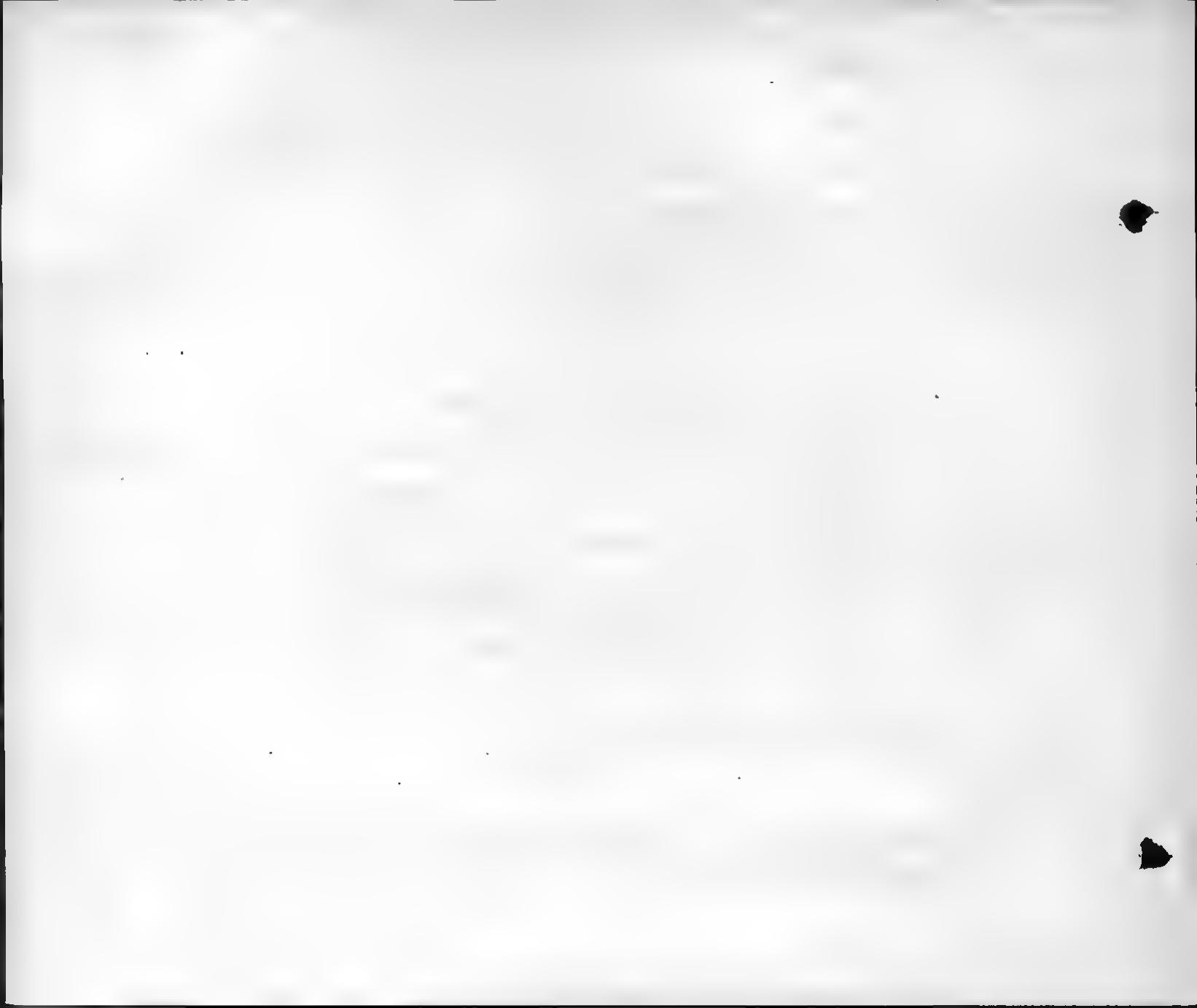
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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

09979

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland		b. COUNTY H-Rford					
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 16 38 yrs lds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street Maryland		d. STREET ADDRESS 12					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Hugh	Middle Andrew	Last Jones	4. DATE OF DEATH September 29	Month September	Day 29	Year 60				
S SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B DATE OF BIRTH May 4, 1893	9 AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Hugh E. Jones		14. MOTHER'S MAIDEN NAME Edith F. Boyle		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 177X					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Bilateral hydronephrosis		DUE TO Urinary retention		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last					
(b) Urinary retention		(c) Carcinoma of the prostate				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Sept. 21 1960						20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept. 21 1960 to Sept. 29 1960, that (I) (we) last saw the deceased alive on Sept. 29 1960, and that death occurred at p. M, from the causes and on the date stated above		22a. SIGNATURE Stella Wachsler		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 9-29-60		
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1960		23c. NAME OF CEMETERY OR CREMATORIAL DARLINGTON, MD.		23d. LOCATION (City, town, or county) DARLINGTON, MD.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Parker Delta, Pa		ADDRESS Delta, Pa		25a. REC'D BY REGISTRAR Oct 3 '60		25b. REGISTRAR'S SIGNATURE John S. Kraus					



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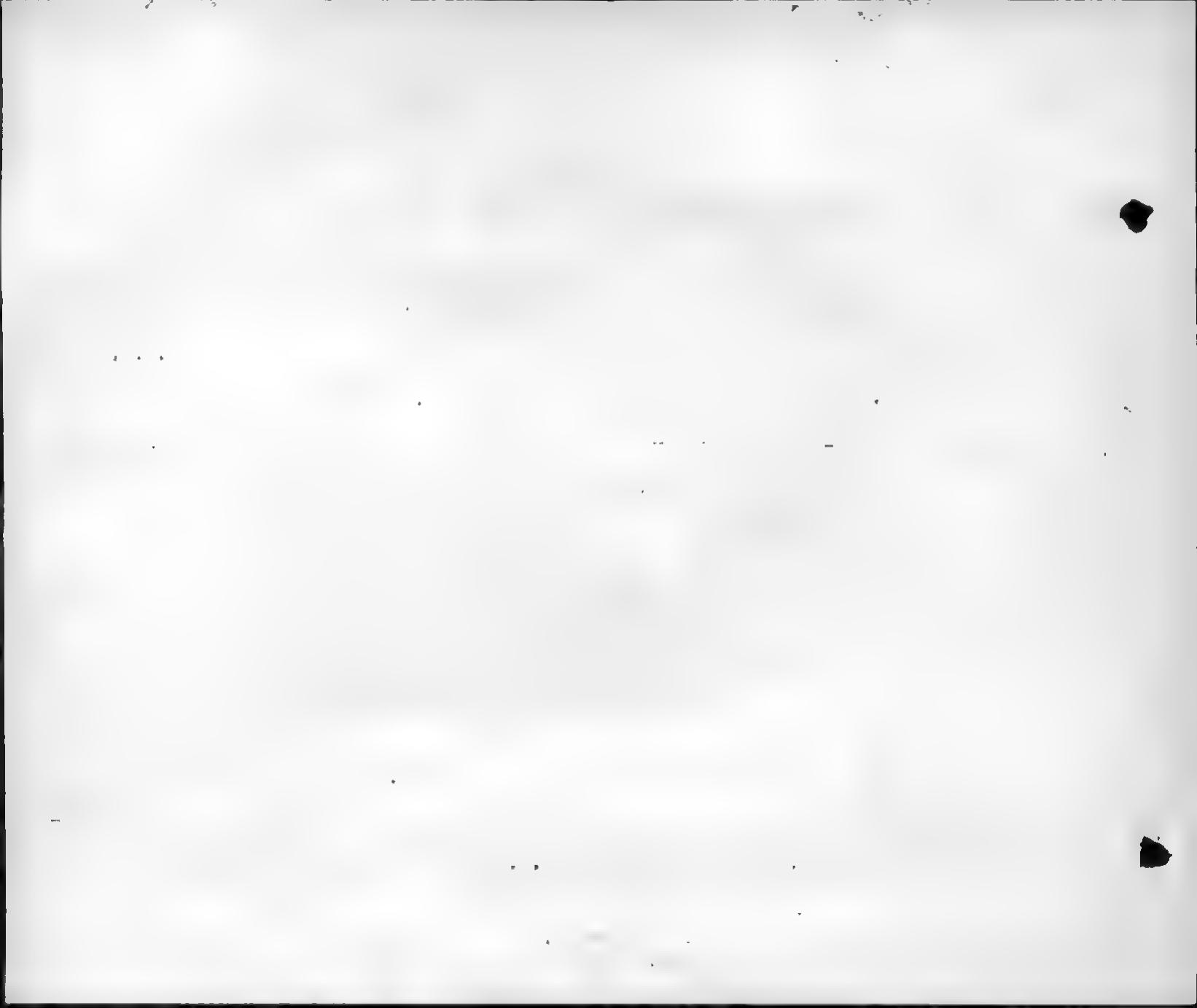
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09980

M

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 50 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) THOMAS		First E	Middle KANE
Last KANE		4. DATE OF DEATH September 24 1960	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH November 21, 1890
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK J. KANE		14. MOTHER'S MAIDEN NAME MARY G. DOUGHERTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES		16. SOCIAL SECURITY NO 218-09-9154	
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a.) 157 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost COMA		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS	
DUE TO CARCINOMA OF PANCREAS		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from August 5 1960 to September 24 1960 , that (X) (we) last saw the deceased alive on September 24 1960 , and that death occurred at 4:45 a.m. from the causes and on the date stated above.		22b. DATE SIGNED 9-24-60	
22a. SIGNATURE E.O. Brown		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS X	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN		22d. ADDRESS M.D. VAH BALTO MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 27/60	
23c. NAME OF CEMETERY OR CREMATORIUM NEW CATHEDRAL CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE KRAUSE FUNERAL HOME Baltimore, Maryland		25a. REC'D BY REGISTRAR SEP 27 '60	
		25b. REG STRR'S SIGNATURE S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

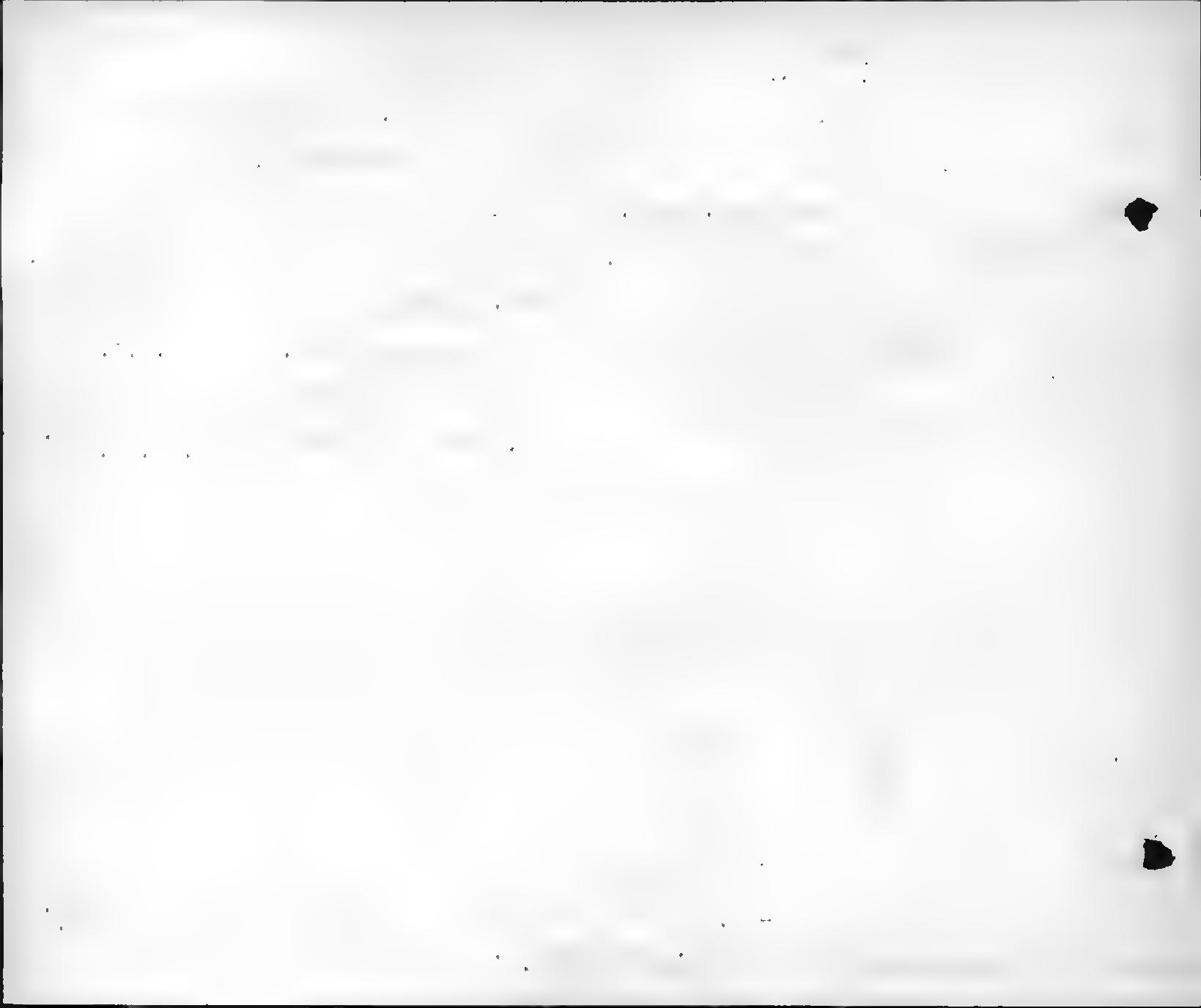
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03981

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if inst. or residence before admission) a. STATE Md.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 6,		d. STREET ADDRESS 3716 Eastwood Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Lodge Conv. Home.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First AMELIA	Middle V.	Last KAVANAUGH	4. DATE OF DEATH Sept. 18, 1960.	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1879	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Conner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		INFORMANT		Address 9103 Yvonne Ave. Balto., 6, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c)		<i>Generalized Carcinomatosis Carcinoma of Colon.</i>				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 17, 1960 , to Sept. 18, 1960 , that I last saw the deceased alive on Sept. 17, 1960 , and that death occurred at 3:45 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 520 38th Balto., Md.		DATE SIGNED 9-18-60	
ACTUAL SIGNATURE <i>James J. Means</i>							
PHYSICIAN'S NAME (Type) James J. Means							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21 -60.		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) Taylor Ave	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Zeller</i>		ADDRESS 901 vs Conkling St. Balto., 24, Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

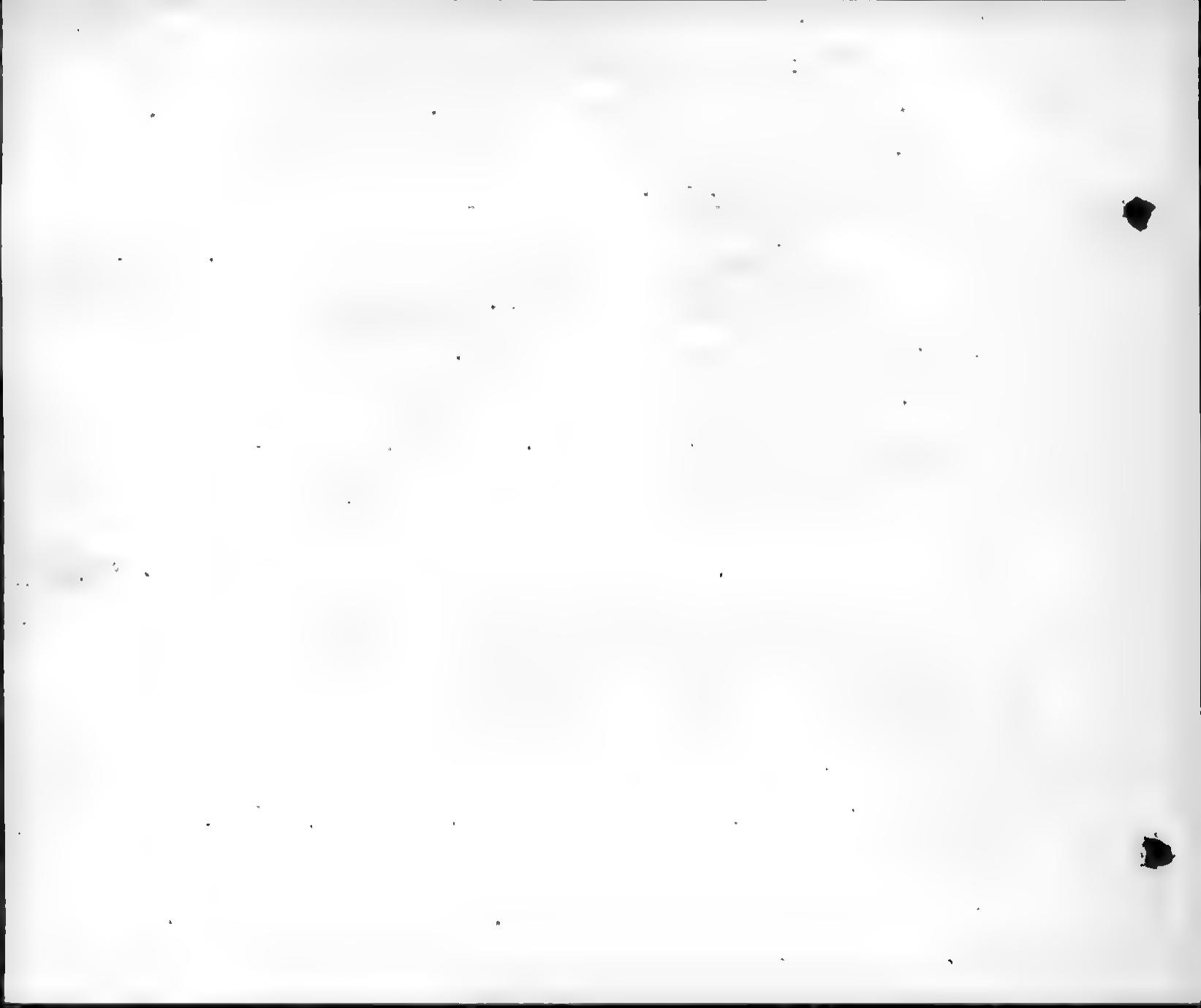
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09982

18022

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6011 Campfield Rd. Augsburg Lutheran Home-				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROSE	Middle —	Last KELLEY	4. DATE OF DEATH	Month Sept.	Day 17,	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1878	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Kelley				14. MOTHER'S MAIDEN NAME Pauline Muhl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO no		INFORMANT Mr. Theodore W. Katenkamp-Augsburg Lutheran H		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO (1) - Cerebral - INTERVAL BETWEEN ONSET AND DEATH 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (2) - Broncho - Pneumonia 4 days (c) (3) Hypertension Heart Disease 10 yrs							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) - Generalized Arterio Sclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1957 , to Sept. 17, 1960 , that I last saw the deceased alive on Sept. 16, 1960 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers — M.D. 4108 Liberty Ht ADDRESS (Street, city or town, state) Balto. Md. DATE SIGNED 9/17/60 PHYSICIAN'S NAME (Type) Earl L. Chambers							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/60	22c. NAME OF CEMETERY OR CREMATORIUM Dixie Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schaefer & Sons - Balt.		ADDRESS 17th and		24a. REC'D BY REGISTRAR Sept. 19 '60		24b. REGISTRAR'S SIGNATURE C. E. L. T. 1960	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

hours by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and death certificate, filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

VR A15 (4)
15M 9/59

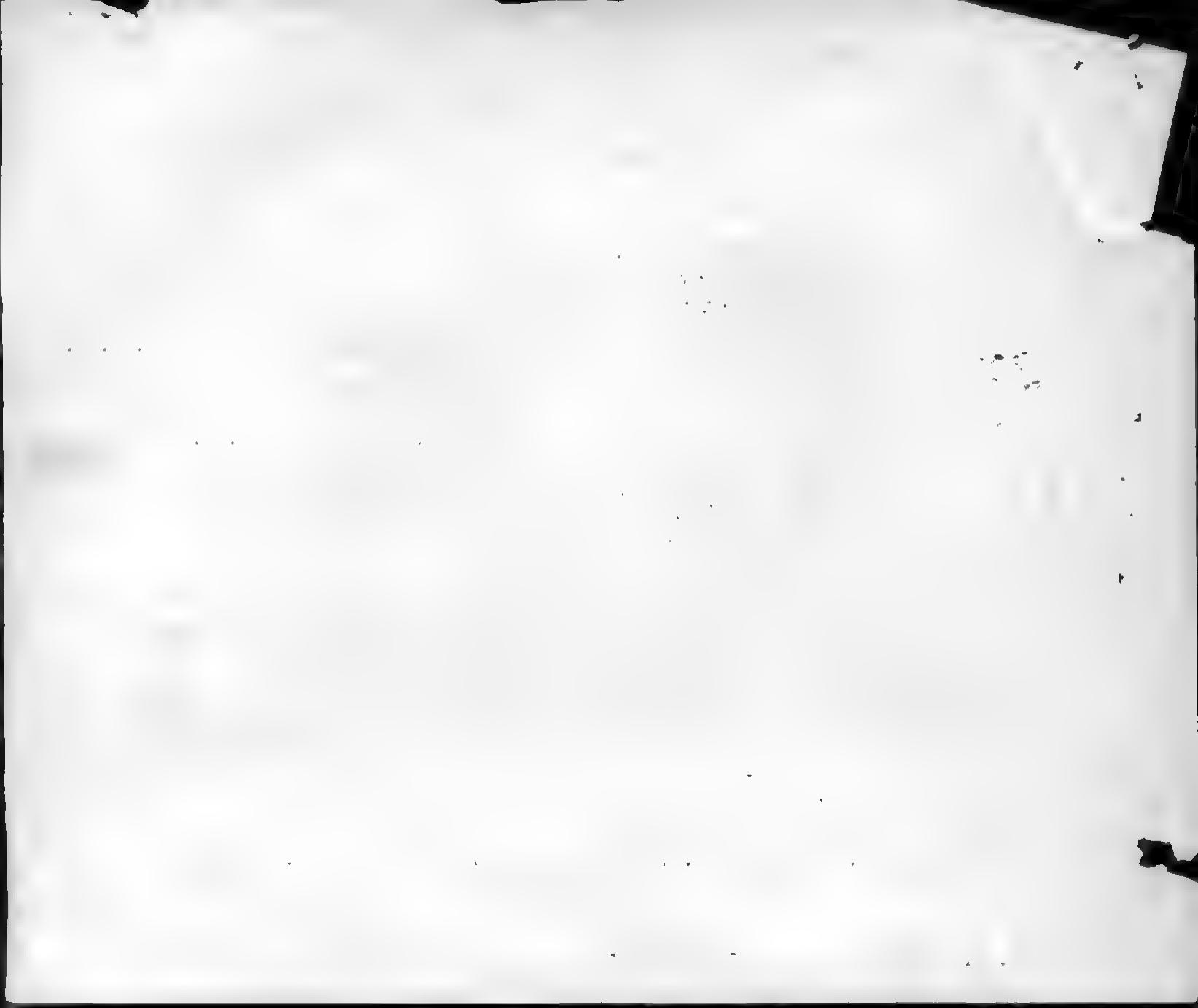
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10023

CERTIFICATE OF DEATH

09983

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
				a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		(24)		
Fort Howard, Md.				Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3714 East Lombard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle P.	Last KELLY	4. DATE OF DEATH September 21	Month September	Day 21	Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 13, 1910	9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Park System		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John J. Kelly				14. MOTHER'S MAIDEN NAME Mary A. Keavney				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT Clinical Rec.VAH,Balto.18,Md.FT.HOWARD DIVISION		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162.1 XQX6 BRONCHOCARCINOMA OF RIGHT MIDDLE LOBE WITH METASTASES TO LYMPH NODES, LIVER, HEART, PANCREAS, BOTH ADRENALS, RIGHT KIDNEY AND LEFT 5TH RIB								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) XQX6 UNKNOWN (c) EDema of the lungs 6 HOURS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) August 31, 1960, to September 21, 1960, at A. M.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 31, 1960, to September 21, 1960, that (I) (we) last saw the deceased alive on 9/21/60 19 and that death occurred at A. M. from the causes and on the date stated above								
22a. SIGNATURE <i>Frederick S. Donaldson</i>		22b. DATE 9/21/60						
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore (State) Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins Funeral Home 4905 York Rd. Balto		ADDRESS .Md.		25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE Charles S. Krause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03984

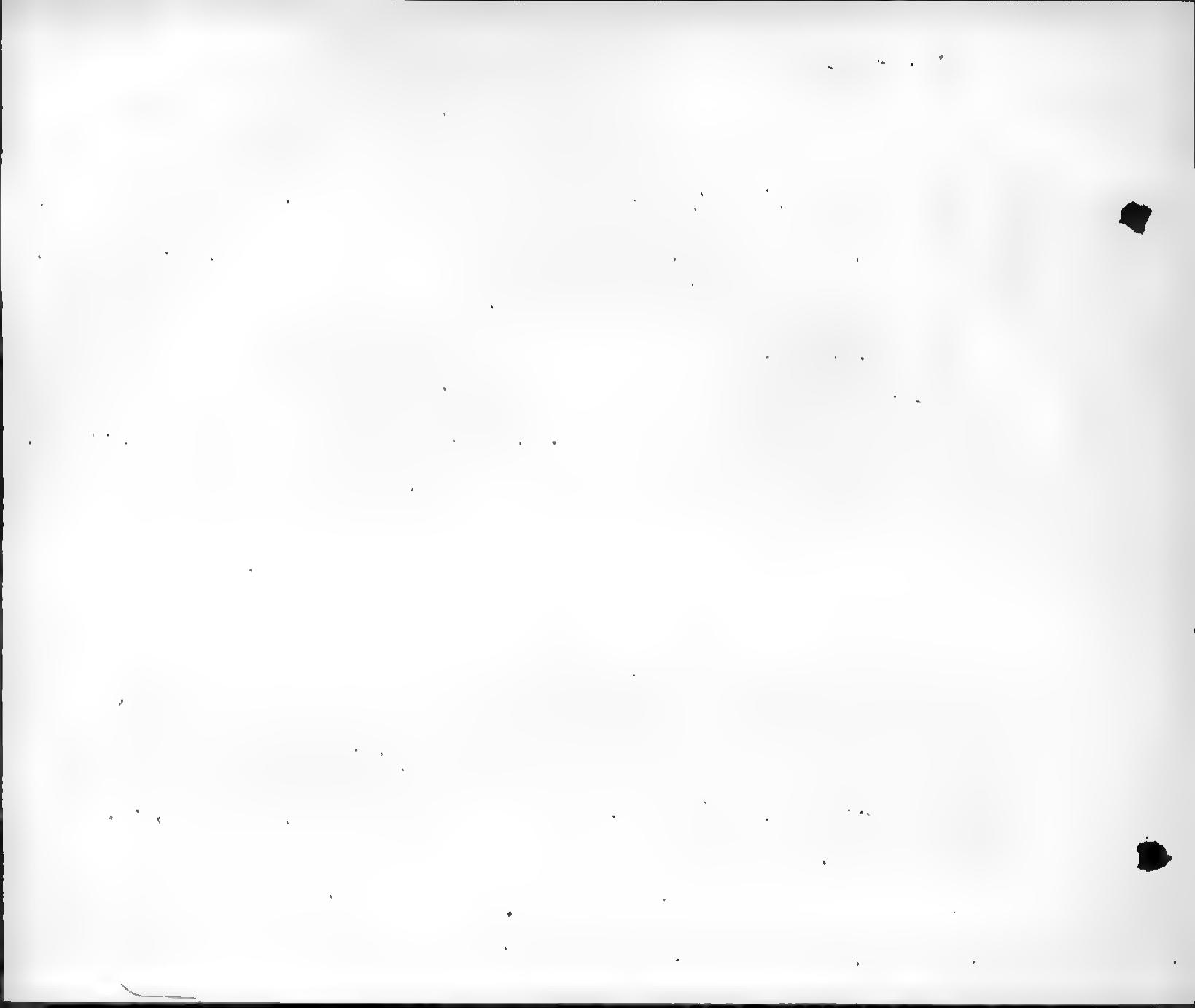
10024

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 548 Valley View Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 548 Valley View Avenue				d. STREET ADDRESS 548 Valley View Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mr. Charles H.		First	Middle	Last	4. DATE OF DEATH September 17, 1960	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1901	9. AGE (in years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Merchant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Kirchner				14. MOTHER'S MAIDEN NAME Caroline				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address Mrs. Lily Kirchner 548 Valley View Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Note DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Note						
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb. 26 , 1960, to Sept. 17 , 1960, that I last saw the deceased alive on Sept. 16 , 1960, and that death occurred at 5:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6210 York Road, Baltimore, Md. DATE SIGNED J.S. Chalfant M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. A. S. Chalfant								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/60		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Traus		
VS A15 (4) 1SM 9/58								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11/12 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09985

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
BALTIMORE				b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB <i>Baltimore - 12</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore (-12)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6467 Blenheim		d. STREET ADDRESS 6467 Blenheim Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LOUISE	Middle 	Last KNOCKE	4. DATE OF DEATH 9 4 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 14, 1885</i>	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Louis Scheide		14. MOTHER'S MAIDEN NAME Louise Pensel		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Vernone Scheide 2100 Lake Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. DUE TO		Hypertensive and ARTERIOSCLEROTIC Heart Disease			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R.S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. S. FISHER		9/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/60		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 9 '60	
				24b. REGISTRAR'S SIGNATURE Charles L. Knapp	

1910. 10. 18.

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1000

1910. 10. 18.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read need by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

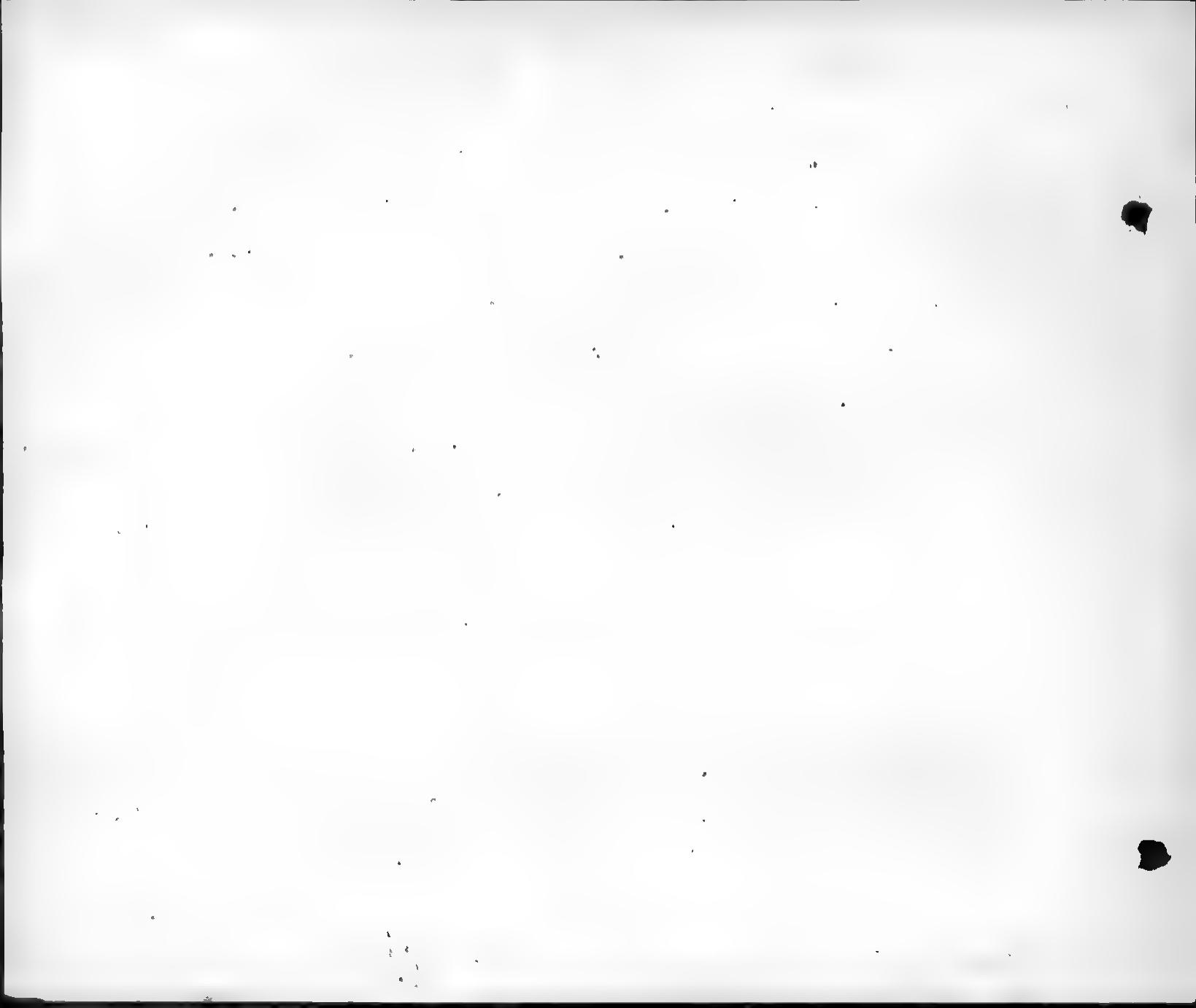
10026

CERTIFICATE OF DEATH

09986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE b. COUNTY Maryland Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Essex		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Essex							
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 707 Stenners Run Rd.		d. STREET ADDRESS 707 Stenners Run Rd.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Stella E.	Middle Kollock	Last Kollock						
4. DATE OF DEATH	Month Sept.	Day 22,	Year 1960						
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 5, 1883						
9 AGE (In years from birth) 76 yrs.	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0	12 IF UNDER 24 HRS Hours 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home							
10c. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12 CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert V. Watson		14. MOTHER'S MAIDEN NAME Emma Pryor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO None							
17. INFORMANT Miss Elizabeth B. Kollock		Address 707 Stenners Run Rd.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last DUE TO (b) DUE TO (c) DUE TO (d) 420 V.D.									
INTERVAL BETWEEN ONSET AND DEATH less than 8 hrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Debile miltus									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE J. PLATT, M.D.				ADDRESS (Street, city or town, state) M.D. 434 Eastern Ave 202-262-2000		DATE SIGNED 9/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-1960		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE SEP 26 '60		24b. REGISTRAR'S SIGNATURE Carlton & Thorne			



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09987

Reg. Dist. No.

9952

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the affidavit, writing the word "pending", in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown,		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. M. E. Strobel's office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathleen		First Carol	Middle Koons
		Last	4. DATE OF DEATH Sept. 13, 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Kenneth C. Koons		14. MOTHER'S MAIDEN NAME Jacqueline Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Kenneth C. Koons, Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia			
925.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) buried in plastic bag.	
20c. TIME OF INJURY Month, Day, Year Hour 7:10 p.m. 9-13-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Westminster, Carroll, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		DATE SIGNED 9-15-60	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16/60	
22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR Callie P. Koon	
		24b. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.



TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your city. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09088

1002

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sparrows Point

c. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address)

Bethlehem Steel Co. Dispensary

MARYLAND

c. LENGTH OF STAY IN lb

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Essex

d. STREET ADDRESS

314 Maple Avenue

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
ALFRED

Middle
Karl

KULECK

4. DATE
OF
DEATH

Month
September 16 1960

Day

Year

5. SEX

White

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Dec. 25, 1915

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Inspector

Steel Industry

9. AGE (in years
last birthday)

44

yrs.

Months

Days

Hours Min.

13. FATHER'S NAME

Julius Kuleck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

Yes

W.W.I

16. SOCIAL SECURITY NO.

203-01-6303

17. INFORMANT

Helen Kuleck

Address

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(IMMEDIATE CAUSE (a))

Arteriosclerotic Heart Disease.

INTERVAL BETWEEN
ONSET AND DEATH

420-0 DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/17/60

ACTUAL
SIGNATURE

Charles S. Petty, M.D.

22e. BURIAL, CREMATION, REMOVAL (Specify)
Burial

22b. DATE THEREOF

Sept. 20, 1960

Oak Lawn Cemetery

ADDRESS

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

James Bruzdinski

1407 Eastern Ave.

ADDRESS

24e. REC'D BY REGISTRAR

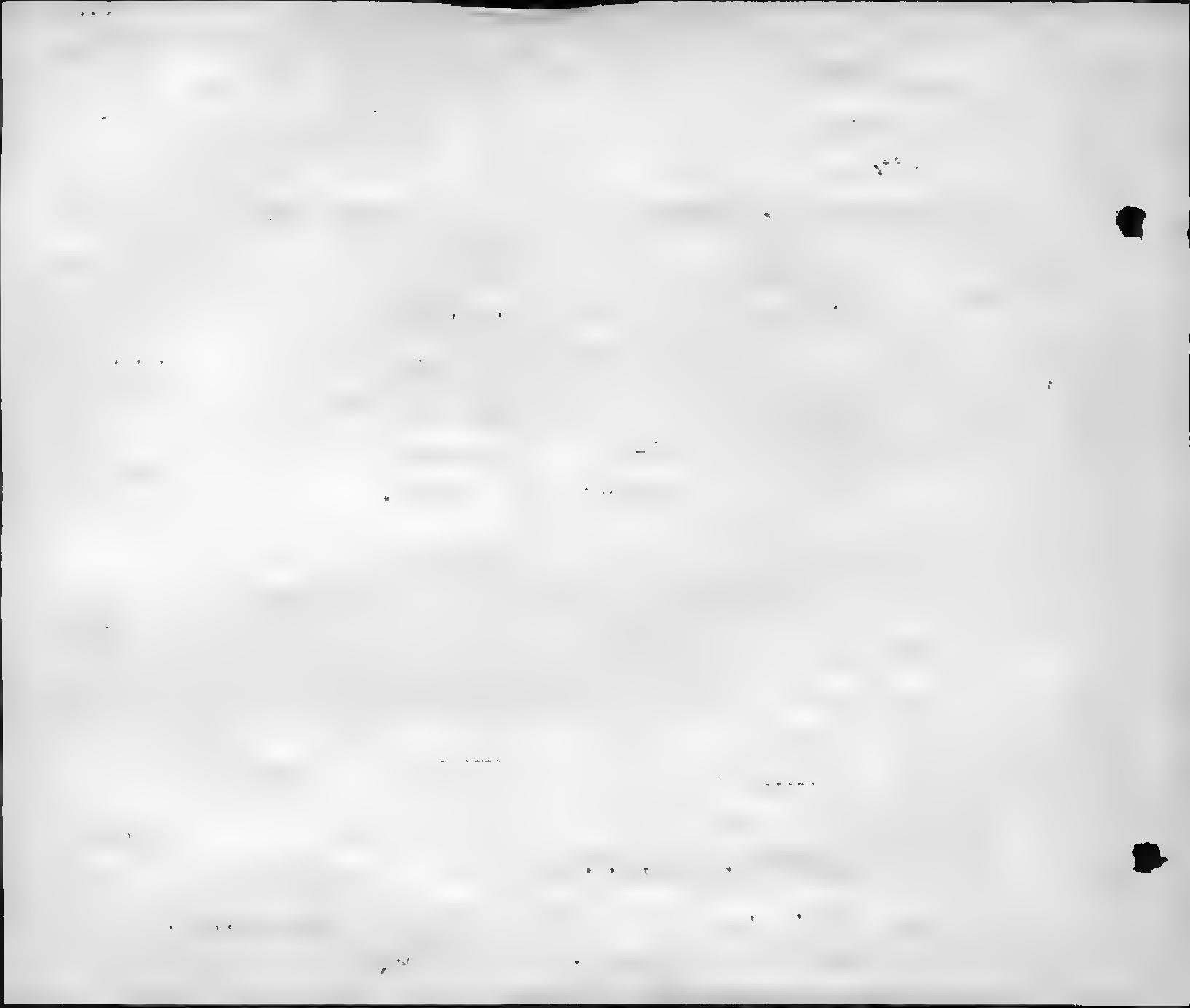
Baltimore Co. Md.

24f. REGISTRAR'S SIGNATURE

DATE

SEP 20 '60

Calvin S. Kraus



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, within 72 hours after death.

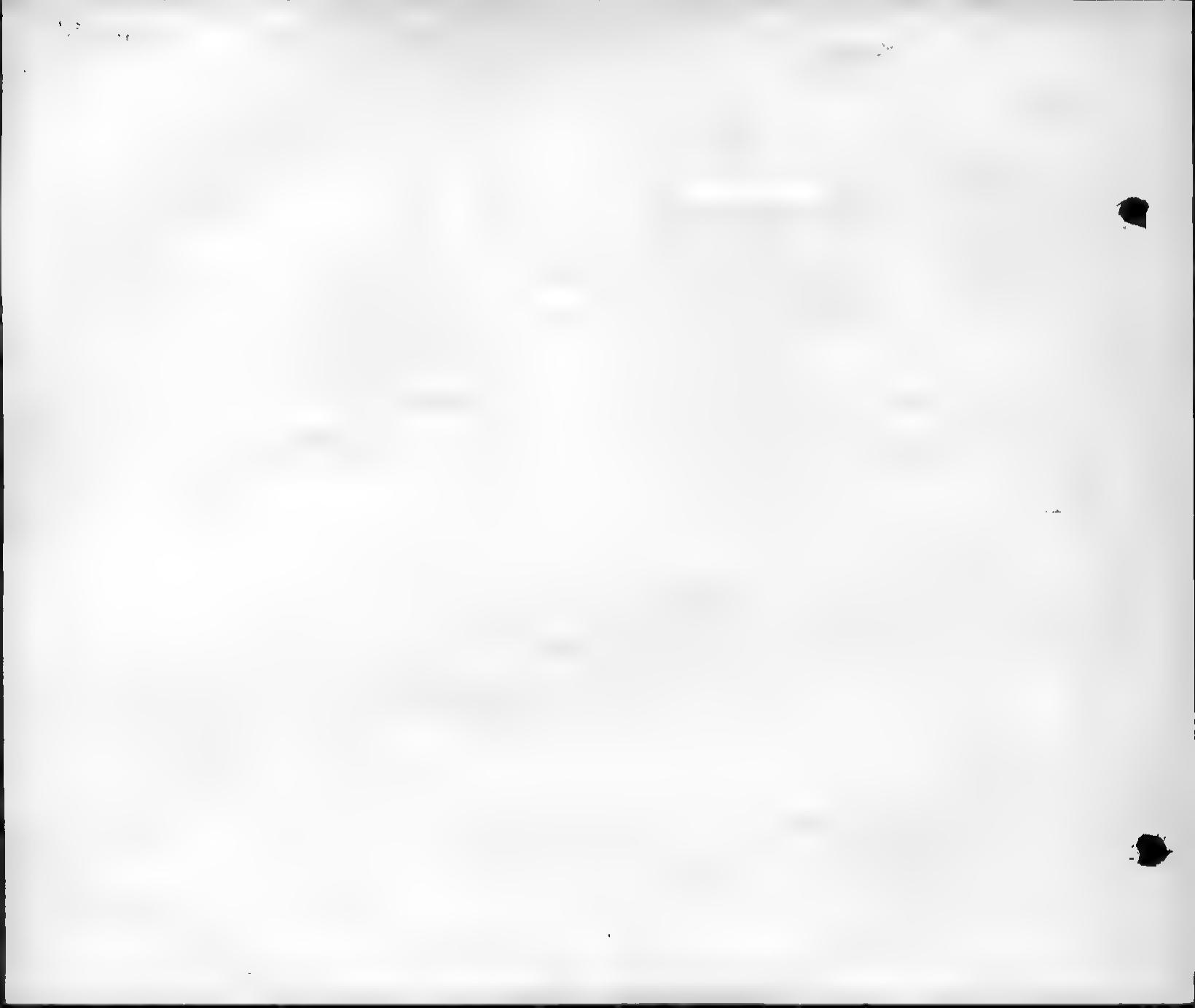
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09989

10028

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>English Consul</i>	c. LENGTH OF STAY IN lb <i>14 yrs</i>	b. COUNTY <i>Baltimore</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>English Consul</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3505 Shenandoah Ave</i>	e. STREET ADDRESS <i>3505 Shenandoah Ave</i>	d. STREET ADDRESS <i>3505 Shenandoah Ave</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Homer E. Lamb Jr.</i>	First <i>Homer</i>	Middle <i>E.</i>	Last <i>Lamb Jr.</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11/13/1945</i>
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Invalid</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Highlands Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>No</i>
13. FATHER'S NAME <i>Homer E. Lamb Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Selma Schumire</i>	Address <i>Mrs Homer E. Lamb Sr. home</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>Yes</i>	16. SOCIAL SECURITY NO <i>- - - - -</i>	17. INFORMANT <i>Mrs Homer E. Lamb Sr.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - Terminal - 3 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>759.5</i>		DUE TO <i>Mental Retardation</i>	INTERVAL BETWEEN ONSET AND DEATH <i>14 years</i>
		DUE TO <i>Mal-development</i>	14 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>11/13/1945</i> to <i>9/27/1960</i> , that (I) (we) lost sow the deceased alive on <i>9/27/1960</i> and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Paul Schonfeld</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Paul Schonfeld</i>	22d. ADDRESS <i>7361 Annapolis Rd</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/30/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cem.</i>	23d. LOCATION (City, town, or county) <i>Ritchie Hwy Md.</i> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son</i>	ADDRESS <i>Collins St.</i>	25a. REC'D BY REG STAR <i>SEP 29 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Fine</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

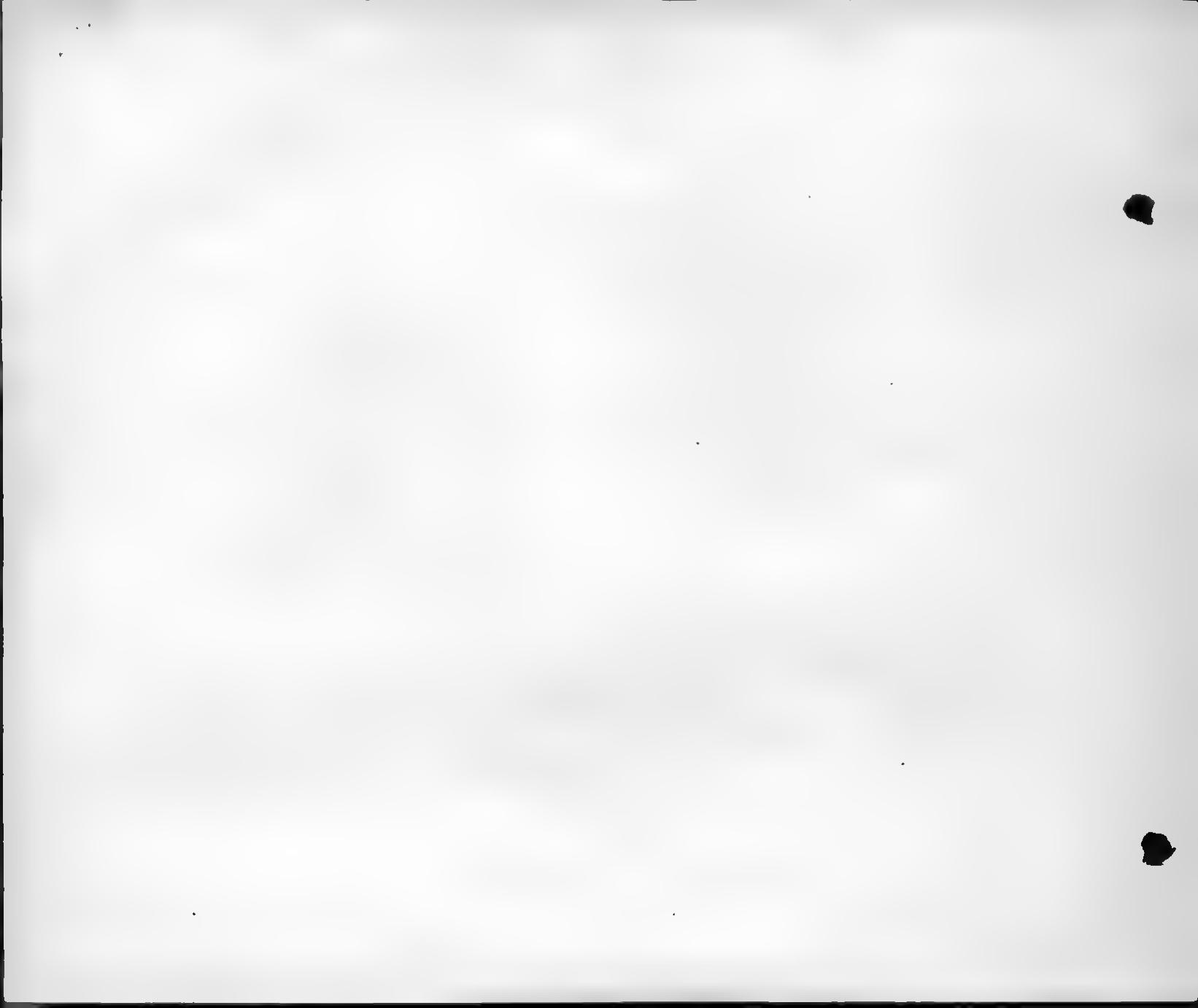
10029

CERTIFICATE OF DEATH

69990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perry Hall</i>	c. LENGTH OF STAY IN 1b <i>16</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Perry Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9822 Richlyn Dr.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First <i>Mary</i>	Middle <i>La</i>	Last <i>Lang</i>
4. DATE OF DEATH <i>Sept 27 1960</i>	Month <i>Sept</i>	Day <i>27</i>	Year <i>1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15 1894</i>
9. AGE (In years lost birthday) yrs <i>65</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mending Sewing</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Sewing</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>Frank Thomas</i>	14. MOTHER'S MAIDEN NAME <i>Rosalie</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>218099808A</i>		17. INFORMANT <i>Mary J. Dudley</i>	Address <i>9822 Richlyn Dr.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>			
INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>4</i> (b) DUE TO <i>Atherosclerosis Cardiovascular Disease</i>			
DUE TO <i>Diabetes mellitus.</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
DUE TO <i>Diabetes mellitus.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Sept 27 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7527 Belair Rd.</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>M.D.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hyde</i>		ADDRESS (Street, city or town, state) <i>7527 Belair Rd.</i>	
PHYSICIAN'S NAME (Type) <i>John C. Hyde</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>SEPT 30 60</i>	22c. NAME OF CEMETERY OR CEMETORY <i>MORELAND MEMORIAL PARK</i>
22d. LOCATION (City, town or county) <i>TAYLOR AVE MO</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Daffel Bros</i>		24a. REC'D BY REGISTRAR DATE <i>ACT 3 '60</i>	24b. REGISTRAR'S SIGNATURE <i>C. Lewis & Evans</i>
ADDRESS <i>7110 BELAIR RD,</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

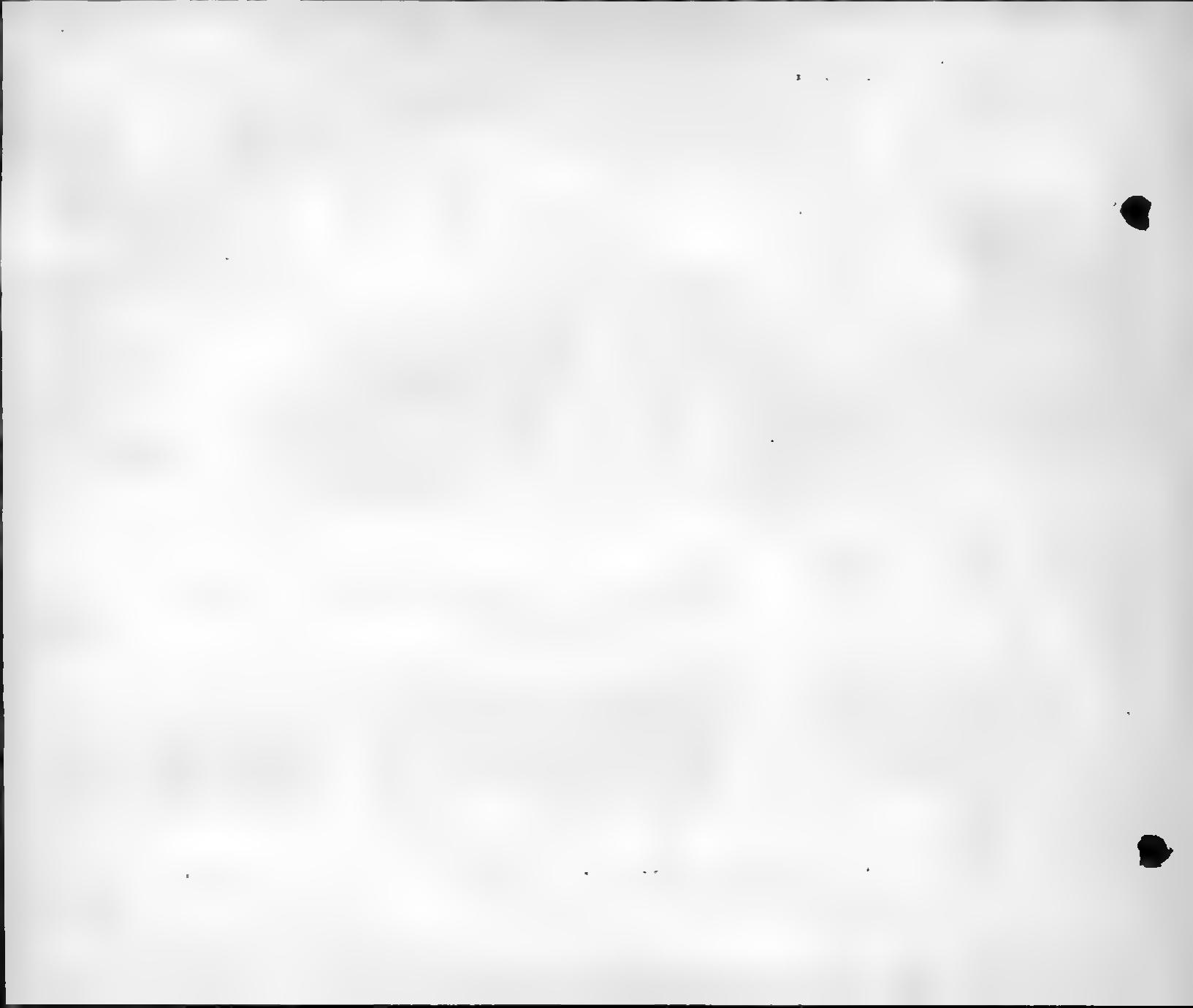
8991

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the file, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2722 Maple St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Eugene	Middle A.	Last Lannon, SA
4. DATE OF DEATH Month Sept. 4, 1960	Day 19	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1898
9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR IBM.		10b. KIND OF BUSINESS OR INDUSTRY BANK	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Lannon		14. MOTHER'S MAIDEN NAME Rosie Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT MRS E. A. LANNON, Sr. Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		DATE SIGNED Sept. 4, 1960	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Parkwood		22d. LOCATION (City, town, or county) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES Evans & Son		ADDRESS 8802 Harford Rd.	
		24a. REC'D BY REGISTRAR DATE SEP 9 '60	
		24b. REGISTRAR'S SIGNATURE Charles Evans	



TO HOSPITAL by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

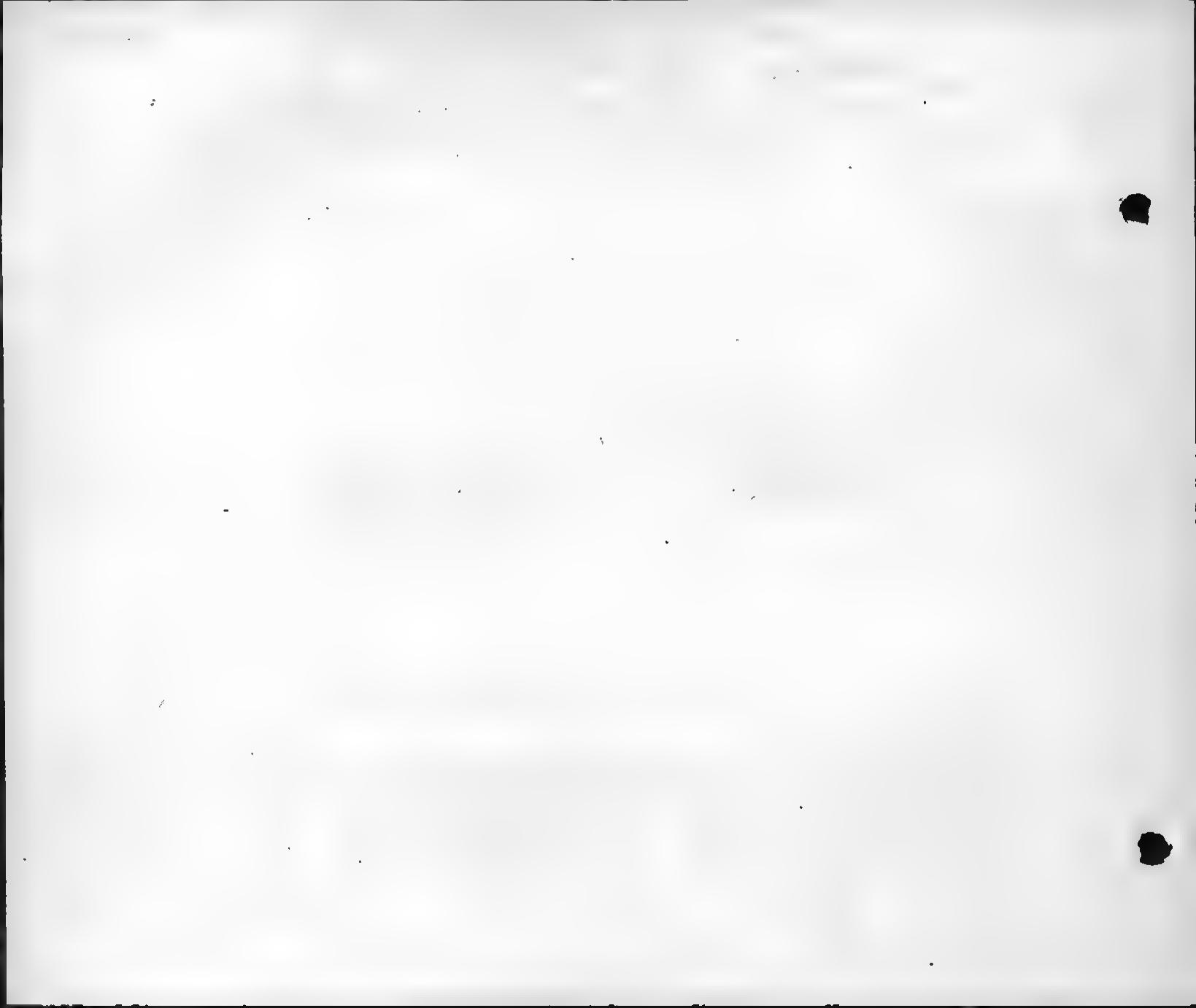
CERTIFICATE OF DEATH

09992

10031

Item No. 2710001-1-2000 et

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pine Lane Home</i>		e. STREET ADDRESS <i>9412 Agnes Lane</i>	
3. NAME OF DECEASED (Type or print) <i>THOMAS J. LANSINGER</i>		First <i>THOMAS</i>	Middle <i>J.</i>
Last <i>LANSINGER</i>		Last <i>LANSINGER</i>	4. DATE OF DEATH <i>Sept. 12 1960</i>
S SEX <i>Male</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <i>1873 April 17, 1874 87 yrs</i>
10a U.S. OR OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Lansinger</i>		14. MOTHER'S MAIDEN NAME <i>Typon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>218-01-2590</i>	
17. INFORMANT <i>Mary Slanko</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced arteriosclerotic & hypertensive</i> (c) <i>Cardiovascular disease</i>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>6 Jan. 1956</i> to <i>12 Sept. 1960</i> , that (I) (<i>me</i>) last saw the deceased alive on <i>10 Sept. 1960</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Emil H. Henning Jr</i>		22b. DATE SIGNED <i>13 Sept. 60</i>	
22c. PHYSICIAN'S NAME (Type) <i>EMIL H. HENNING JR</i>		22d. ADDRESS <i>601 WINANS WAY BETHU 24-261</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Funeral</i>		23b. DATE THEREOF <i>9/15/60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge</i>		23d. LOCATION (City, town or county) (State) <i>Howard Co. Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Don 28</i>		25a. REC'D BY REGISTRAR DATE SEP 16 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>C. Hunt & Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09993

10032

CERTIFICATE OF DEATH

1. PLACE OF DEATH

o. COUNTY
Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard, Md.

c. LENGTH OF STAY IN 1b
5 Hrs. 40 M.d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Veterans Administration Hospital3. NAME OF
DECEASED
(Type or print)First
HARDYMiddle
----Last
LASSITER4. DATE
OF
DEATHMonth
September
Day
21
Year
1960

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

December 25, 1895

9. AGE (In years
last birthday)

64

yrs

10. U.S.A. OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY
/Ord Depot.

Wilson N. Carolina

12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

John Lassiter

14. MOTHER'S MAIDEN NAME

Isabelle Gear

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

216-05-9157

17. INFORMANT

Clin. Rec., VAH, Balto. 18, Md. FT. HOWARD DIVISION

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

ACUTE EDEMA OF LUNGS

INTERVAL BETWEEN
ONSET AND DEATH
4 HOURSConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

(b)

DUE TO
HYPERTROPHY AND DILATATION OF THE HEART
ANEURYSM, ABDOMINAL AORTA

UNKNOWN

(c)

MARKED GENERALIZED ARTERIOSCLEROSIS

UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Sept. 21, 1960, to Sept. 21, 1960, that (we) lost
the deceased alive on Sept. 21, 1960, and that death occurred at P. M., from the causes and on the date stated above

22a. SIGNATURE

Frederick S. Donaldson, M.D.

M.D. ATTENDING PHYS MED. DIRECTOR STAFF PHYS 22b. DATE
9/26/6022c. PHYSICIAN'S
NAME (Type)22d. ADDRESS
VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

9/26/60

23c. NAME OF CEMETERY OR CREMATORIUM

Baltimore National

23d. LOCATION (City, town, or county) (State)

Baltimore Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

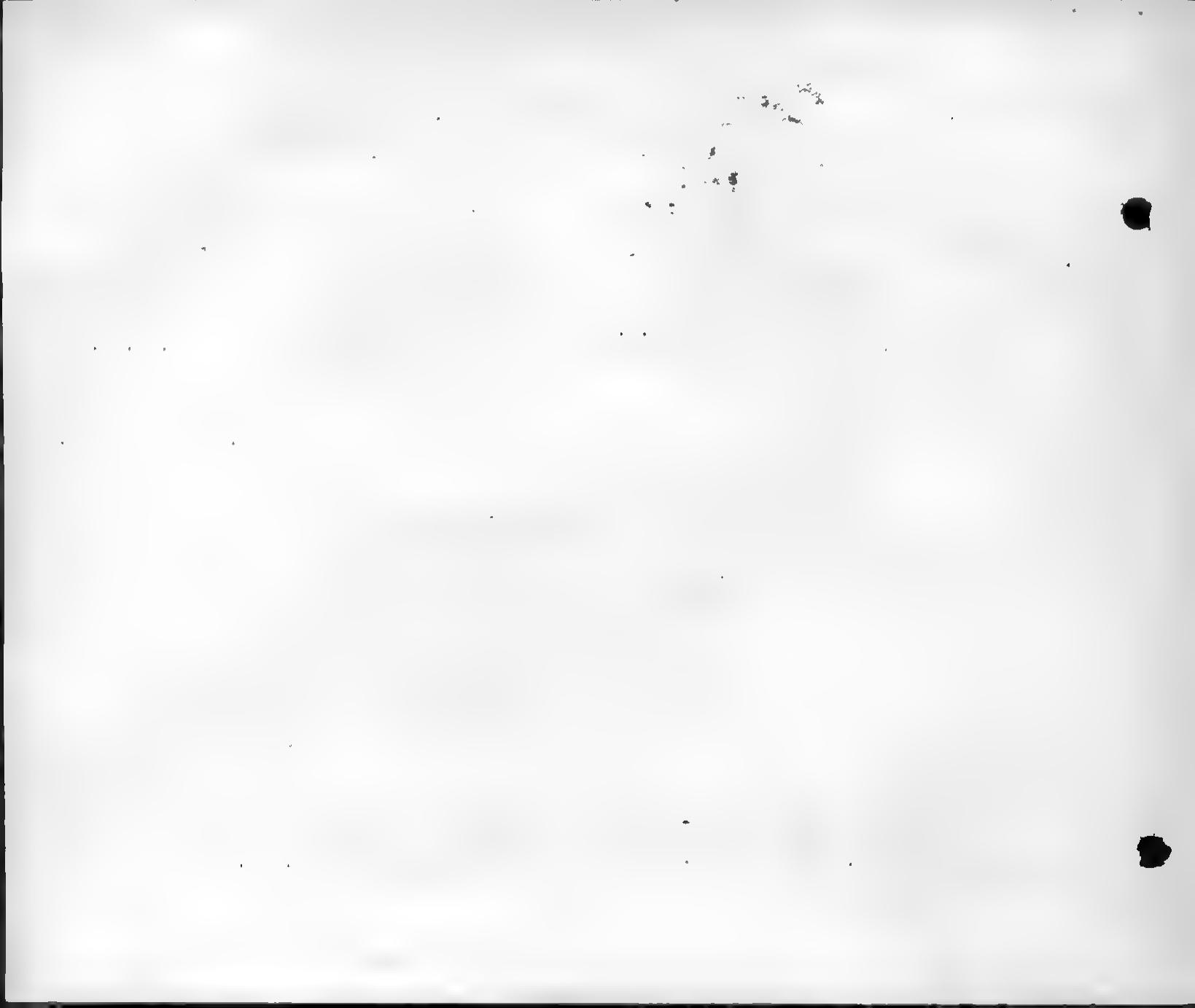
ADDRESS
Arlington S. Phillips 1808 N. Monroe St. Balto. 17

25a. REC'D BY REGISTRAR

DATE SEP 28 '60

25b. REGISTRAR'S SIGNATURE

John S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rec'd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if any agent, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

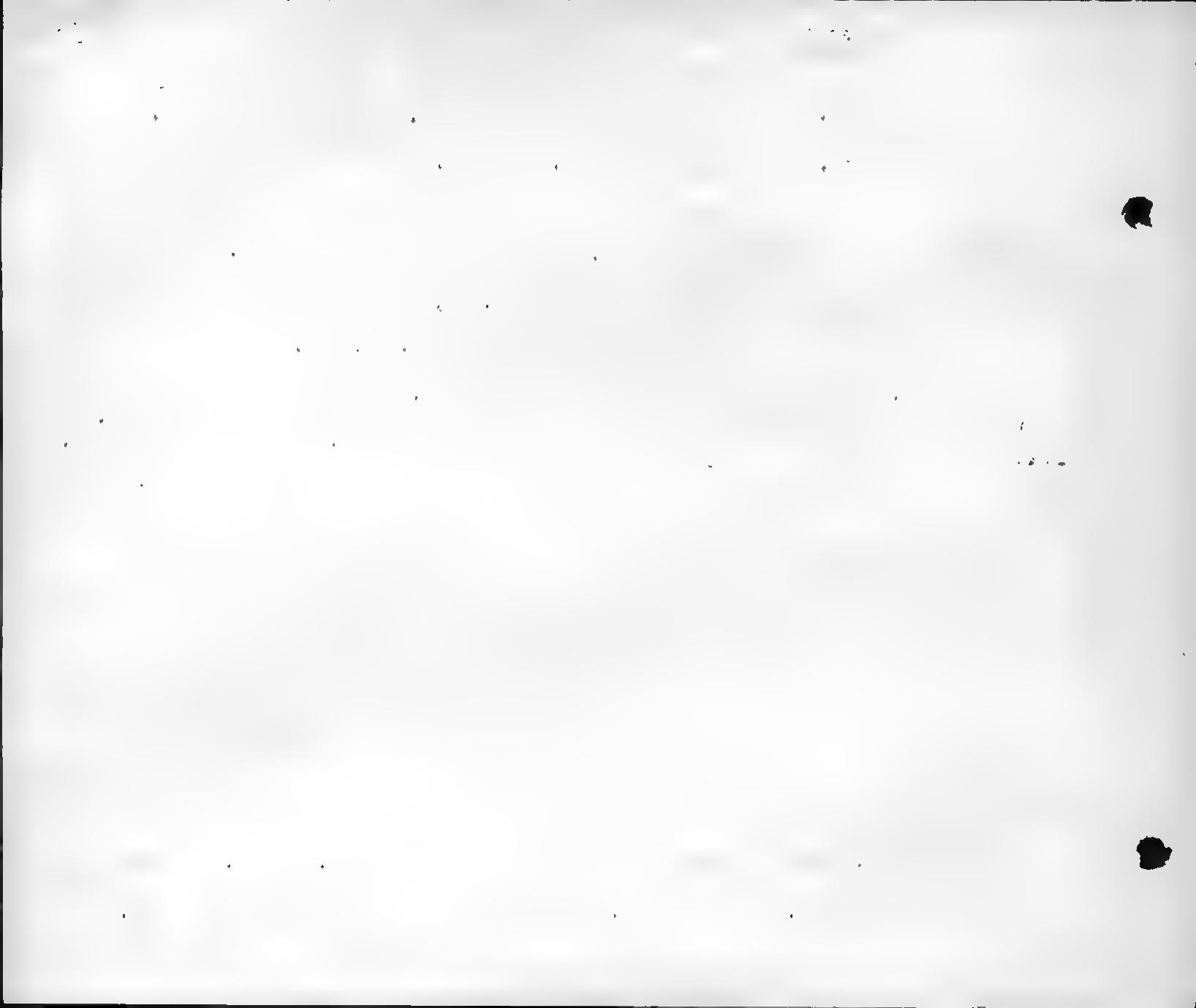
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09994

10033

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale Balto. 7		c. LENGTH OF STAY IN 1b 1 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 7		d. STREET ADDRESS 3616 Kenmar Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Marie	Middle E.	Last Liebno	4. DATE OF DEATH Sept. 20 1960	Month Sept.	Day 20	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1883		9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 1 Days 1 Hours 0 Min. 0 IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George W. Sauter		14. MOTHER'S MAIDEN NAME Annie E. Schlining		Address Balto. 7				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Lillian E. Sauter 3616 Kenmar Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		DUE TO <i>Coronary Thrombosis</i> <i>Hepatomegaly C. V. Renal Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 10 Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, if item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug. 15 1960 to Sept. 20 1960 that (I) (we) last saw the deceased alive on Sept. 14 1960 and that death occurred at 4:30 P.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>Edwin Pierpont</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED Sept. 23 1960		
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont		22d. ADDRESS 8204 Liberty Rd. Balto. 7, Maryland						
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers 8728 Liberty Rd.</i>		ADDRESS <i>Randallstown, Md.</i>		25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE Charles S. Krause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09995

10034

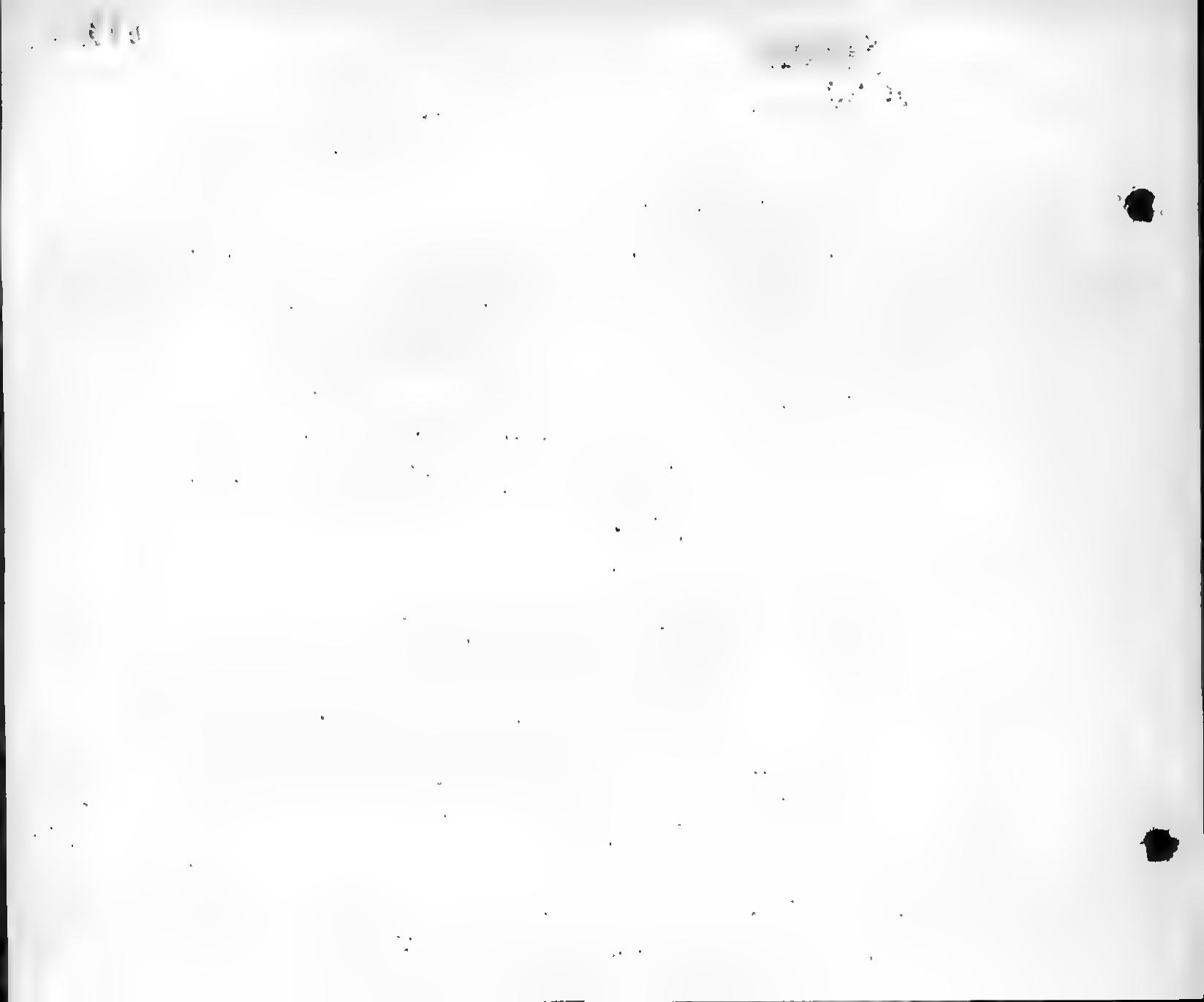
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 52		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunnyside Nursing Home 98 Smithwood Avenue				d. STREET ADDRESS 1601 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs. Laura J.		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 24, 1872	9. AGE (in years last birthday)	IF UNDER 1 YEAR, IF UNDER 24 HRS	Months	Days	Hours	Min.
88 yrs.						Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Thomas Bussey		14. MOTHER'S MAIDEN NAME ?		Gleason						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT Mrs. Agnes Hubbard 5007 Hillen Road		Address				
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Hyperensive Cardio-Vascular Disease with Acute & Chronic Failure		INTERVAL BETWEEN ONSET AND DEATH				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Scalp Laceration rt. occiput Recent.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I or item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Feb 60 9/19/60				
21. I certify that I attended the deceased from alive on 9/16/60 19		and that death occurred at 11:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1303 Frederick Rd Catonsville 28nd		DATE SIGNED 9/17/60				
ACTUAL SIGNATURE W.E. McGrath										
PHYSICIAN'S NAME (Type)										
22a. BUR AL, CREMAT ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/60		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 22 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline				

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10035

CERTIFICATE OF DEATH

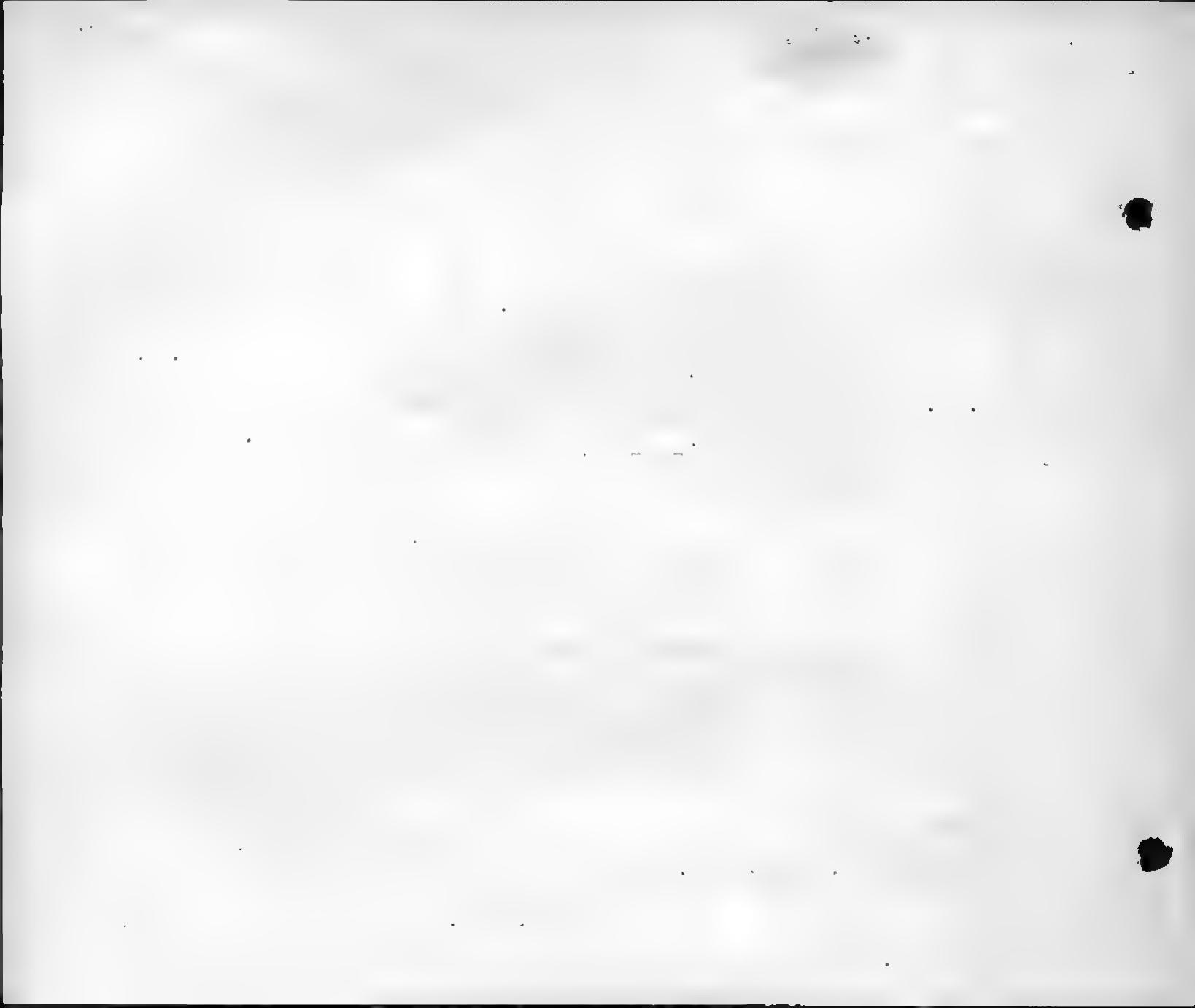
09996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 1 Yr. 10 Das		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 15H4-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital		d. STREET ADDRESS 5903 Lone Oak Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Elmer Lynch		First Middle Last	4. DATE OF DEATH September 5 1960
5. SEX Male White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 21, 1895		9. AGE (In years last birthday) 64 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman		10b. KIND OF BUSINESS OR INDUSTRY Hardware firm providing supplies for	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Geo. W. Lynch		14. MOTHER'S MAIDEN NAME Annie McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I 577-22-8043	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 43 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days Generalized arteriosclerosis 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Brain Syndrome due to unknown Cause		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25, 1959 to Sept 5, 1960, that I last saw the deceased alive on Sept 5, 1960, and that death occurred at 4:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Sheppard and Enoch Pratt Hospital Towson 4, Maryland	
ACTUAL M.D. W. W. Elgin, M. D.		DATE SIGNED September 6, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/60	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 9 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10036 CERTIFICATE OF DEATH

Reg. Dist. No. 09997

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
Baltimore				a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Catonsville		c. LENGTH OF STAY IN 1b 1 day		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION House In The Pines, Catonsville, Md.		d. STREET ADDRESS 202 Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elmer Miller		First	Middle	Last	4. DATE OF DEATH September 24, 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8 1887	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Lumber Yard Nursery		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lutherville, Md.	
13. FATHER'S NAME William Miller		14. MOTHER'S MAIDEN NAME Sophia Trebilway		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 215-20-8555		INFORMANT Mrs. Frances N. Andrews, 1755 Wentworth	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca. of Pancreas with Metastasis to lungs				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15 th , 1960, to Sept 24 th , 1960, that I last saw the deceased alive on Sept 21 st , 1960, and that death occurred at 10:45 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1331 Reisterstown Rd. Pikesville 8, Md. DATE SIGNED 9/26/60	
ACTUAL SIGNATURE James A. Miller, M.D.					
PHYSICIAN'S NAME (Type) James A. Miller, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery	
22d. LOCATION (City, town, or county) Pikesville 8, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Newell, Pikesville 8, Md.		ADDRESS		24a. REC'D BY REGISTRAR SEP 30 '60	
				24b. REGISTRAR'S SIGNATURE Elmer E. Krause	



1

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

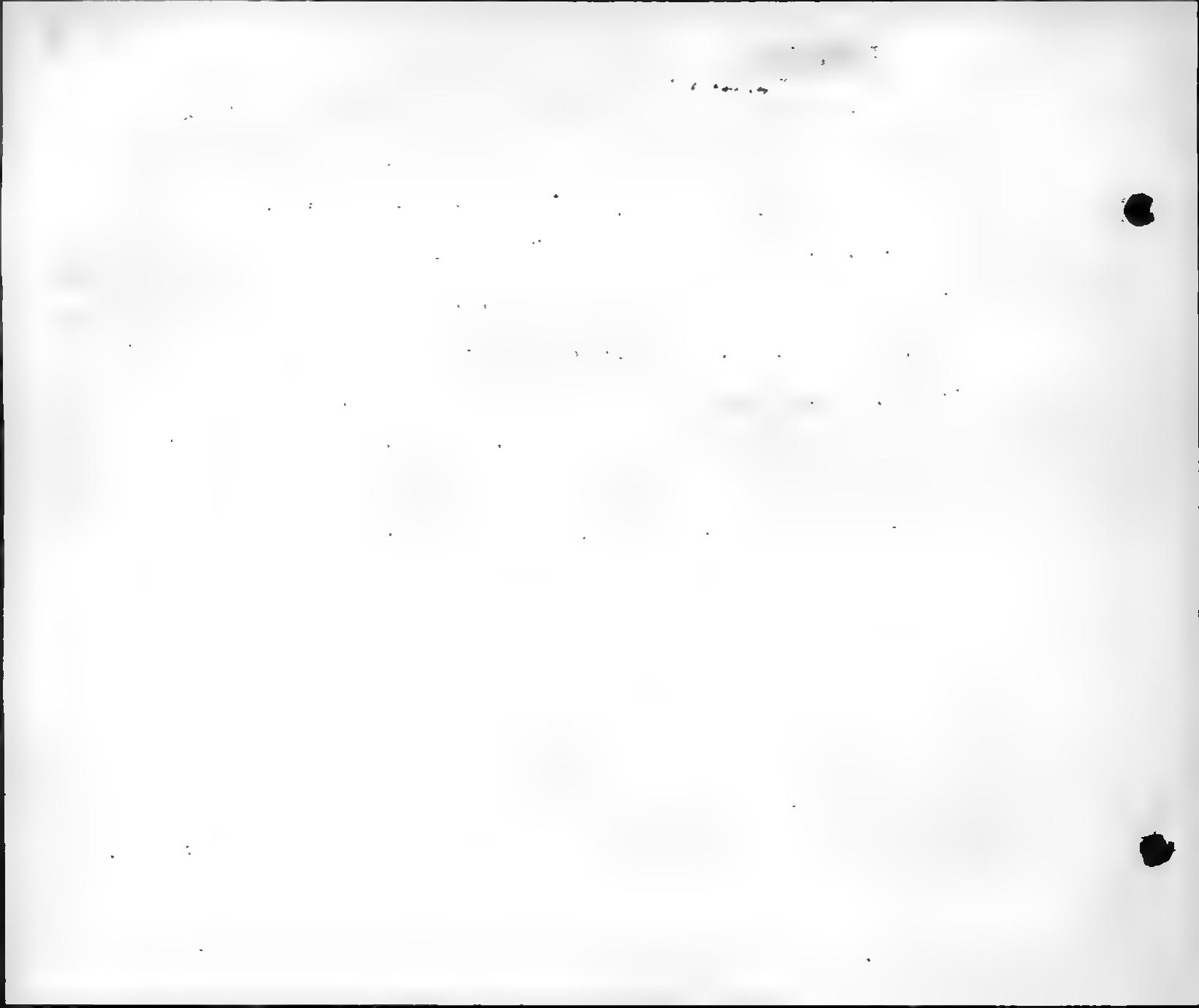
10037

CERTIFICATE OF DEATH

09998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8013 Duvall Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Robert Grafflin Mansfield		First	Middle
		Last	
4. DATE OF DEATH September 17, 1960		Month	Day
		Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>
		DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Armco Co. Grinding Dept. Maryland		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR IF UNDER 24 HRS yrs. Months Days Hours Min
10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Mansfield		14. MOTHER'S MAIDEN NAME Annie Potts.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Margaret Agnes Mansfield	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) DUE TO (c)		INFORMANT Address Coronary occlusion Arteriosclerotic Heart Disease 1 hr. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) Sept 17, 1960	
21. I certify that I attended the deceased from Sept 1, 1960 , to Sept 17, 1960 that I last saw the deceased alive on Sept 1, 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore, Md	
ACTUAL SIGNATURE Sonnete Polkens		DATE SIGNED Sept 19, 1960	
PHYSICIAN'S NAME (Type) EMMETT P DAVIS		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-60	
22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS Leonard J. Ruck 5305 Harford Road #14	24a. REC'D BY REGISTRAR DATE SEP 22 '60
		24b. REGISTRAR'S SIGNATURE Cuthbert S. Kimes	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9945

CERTIFICATE OF DEATH

09999

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write name and any nearest town)
Rosemont

c. LENGTH OF STAY IN 1b

2809 Pennsylvania Ave.

d. NAME OF HOSPITAL (If not in hospital, give street address)

2809 Pennsylvania Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

51 Rosemont

d. STREET ADDRESS

2809 Pennsylvania Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

LAURITZ MATHISON (also Laurets & Lewis)

First Middle Last

4. DATE
OF
DEATH

Sept. 18, 1960

Month Day Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 10, 1882

9. AGE (In years
less birthday)
yrs.

78

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done)

Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Norway

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Lawrence Mathison

14. MOTHER'S MAIDEN NAME

Caroline (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or date of service)

none

16. SOCIAL SECURITY NO.

217 07 4019 Thilda E. Mathison, 2809 Pennsylvania Ave

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

117X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

cardiac - coronary insuffi - pulse E.C.G.

ca of morta.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-27-1959 to 9-18-1960, that (I) (we) last saw the deceased alive on 9-18-1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above

22a. SIGNATURE

Eugene Schnitzer

M.D.

ATTENDING PHYS

MED DIRECTOR

STAFF PHYS

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Eugene Schnitzer, M.D.

22d. ADDRESS

3904 S. Hanover St., Balt., Md.

23a. BURIAL, CREMATION,
REMOVAL (Select)

Burial

23b. DATE THEREOF

9/22/60

23c. NAME OF CEMETERY OR CREMATORI

Meadow Ridge

23d. LOCATION (City, town, or county)

Howard Co., Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Howard H. Hubbard 4107 Wilkens Ave

ADDRESS

25a. REC'D BY REGISTRAR

DATE SEP 21 '60

25b. REGISTRAR'S SIGNATURE

John S. Turner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

CERTIFICATE OF DEATH

10000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Coventry"		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coventry, Balto Co. (Balto-34)	
3. NAME OF DECEASED (Type or print) JAMES A. WARD		First JAMES	Middle WILLIAM
4. DATE OF DEATH SEPTEMBER 17 1960	Month Month	Day Day	Year Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 26 1883
			9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired c'ahon Transportation Co.)		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
10c. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Shipley Maxwell		14. MOTHER'S MAIDEN NAME Elizabeth Yearly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. E.I. Maxwell (son) Kingsville Md.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Generalized arterosclerosis Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause first. Diabetes mellitus. DUE TO Diabetes mellitus. (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes 10 years Only 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Sept 19 1960		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1946 to 16 Sept 1960 , that I last saw the deceased alive on 15 Sept 1960 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Fairiston L. Keown M.D. PHYSICIAN'S NAME (Type) Fairiston L. Keown		ADDRESS (Street, city or town, state) 431 East Lake Ave DATE SIGNED Baltimore 12 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept-20-60		22b. DATE THEREOF Green's int	
22c. NAME OF CEMETERY OR CREMATORIUM Green's int		22d. LOCATION (City, town, or county) Baltimore E. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart & Bowen Co., 108-W-North-Av. Balto 1, Md		ADDRESS	
		24a. REC'D BY REGISTRAR DATE SEP 19 '60	
		24b. REGISTRAR'S SIGNATURE Charles J. Morris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10001

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN lb Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sister Mary Josefita McCloskey	Middle	Last
4. DATE OF DEATH	Month Sept.	Day 5	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 18, 1877
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Saratoga Springs, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael MC Closkey	14. MOTHER'S MAIDEN NAME Mary Ann Cody		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or date of service)	17. INFORMANT Sister M. Peter Fourier	Address Notch Cliff, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of large bowel- metastasis to bone & lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.9 Uremia due to above. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 18, 1956 , to Sept. 1960 , that I last saw the deceased alive on August 31, 1960 , and that death occurred at 2:15A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>	ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED 9/5/60		
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-7-60.	22c. NAME OF CEMETERY OR CREMATORIUM VILLA MARIA CEM.	22d. LOCATION (City, town, or county) NOTCH CLIFF NR TOWSON, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles F. O'Donnell</i>	ADDRESS 901 S. CONKLING ST.	24a. REC'D BY REGISTRAR SEP 8 '60	24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 10-20-60 et

10040

10002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL PIKESVILLE

c. LENGTH OF STAY IN 1b

10 YRS.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

ROBB COINVAL HOME PIKESVILLE, MD.

3. NAME OF
DECEASED
(Type or print)

Irene

First Middle Last

McDonald

DATE
OF
DEATH

Sept

29

1960

4. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Aug 16, 1878

9. AGE (in years
last birthday)

82 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesclerk

10b. KIND OF BUSINESS OR INDUSTRY

DEPT STORES

11. BIRTHPLACE (State or foreign country)

YORK CO., PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

AGUILA McDONALD

14. MOTHER'S MAIDEN NAME

SARAH GEMMILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-01-9957

INFORMANT

Drene Anderson

Address

Jarrettsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (b)

321
Cerebral vascular accident

DUE TO

Conditions, if any which
gave rise to immediate
cause (b), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

11 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.

20d. INJURY OCCURRED
White Not white
at work at work

20e. PLACE OF INJURY (Name, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Sept 7, 1960, and that death occurred at 6:40 PM, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Paul H. Royste

M.D.

1403 Folciy Lane 29 Sep 60
Pikesville 8 M.L

PHYSICIAN'S
NAME (Type)

Tau H. Royste

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

10-2-1960

22c. NAME OF CEMETERY OR CREMATORIUM

CENTRE PRESBY.CEM.

22d. LOCATION (City, town, or county)

New Park, York Co., Pa.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Kenneth W. Abraham Steverstoen Pa.

ADDRESS

24a. REC'D BY REGISTRAR
DATE OCT 4 '60

24b. REGISTRAR'S SIGNATURE
Ollie S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

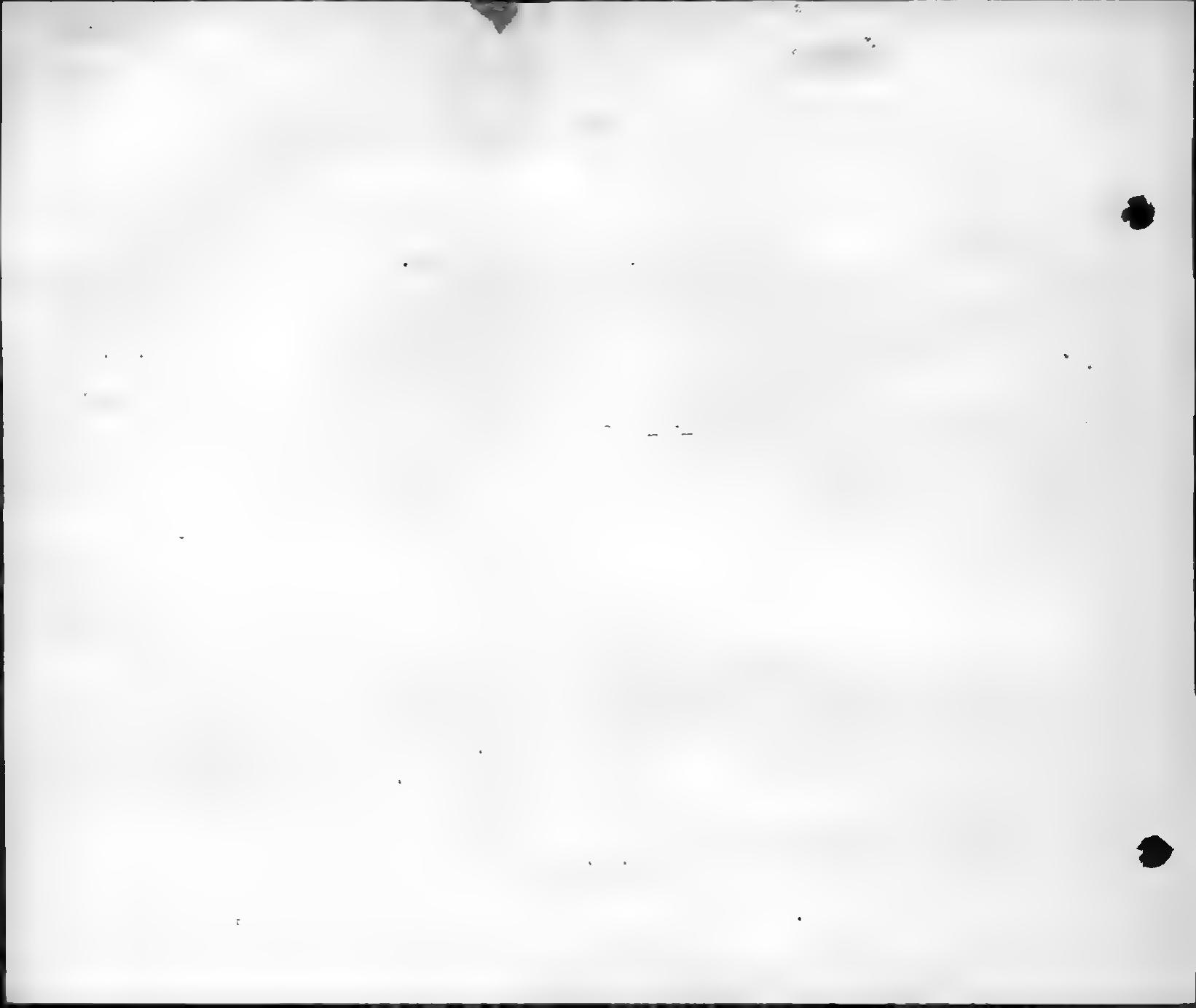
10003

M

10041

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 542 West University Parkway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Neal	Last McFaull Jr.	4. DATE OF DEATH September 21	Month September	Day 21	Year 1960
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH October 16, 1903	8. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months 56	IF UNDER 24 HRS Hours 56	IF UNDER 24 HRS Min 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10b. KIND OF BUSINESS OR INDUSTRY medicine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William McNeal McFaull		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) No (Unknown)		16. SOCIAL SECURITY NO 218-38-2923	
17. INFORMANT unknown		18. RECORDS: SPRING GROVE STATE HOSPITAL		19. ADDRESS			
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis							
DUE TO (c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral acute pyelonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While at work					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Pikesville, Maryland	
21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960, to Sept. 21, 1960, that (I) (we) last saw the deceased alive on Sept. 21, 1960, and that death occurred at 2:40 p. m., from the causes and on the date stated above.							
22a. SIGNATURE Stella Wechsler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-21-60			
22c. PHYSICIAN'S NAME (Type) Stella Wechsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road		25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE Carroll S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9946 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10004

FOR STATE
HEALTH DEPT.

M

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an extension is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Arbutus

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1244 Ten Oak Road

First

Middle

d. STREET ADDRESS

1244 Ten Oak Road

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

MARK

ANDREW

McKISSICK

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 4. DATE
OF
DEATH

September 30 1960

8. DATE OF BIRTH

8/18/60

9. AGE (In years) (If under 1 year, list birthday)

yrs 1 months 14 days 0 hours 0 minutes

10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired)

Baby

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore
Md.

13. FATHER'S NAME

Billy D. McKissick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Billy D. McKissick 1244 Ten Oaks Rd.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)492 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(b)
DUE TO
(c)

Interstitial Pneumonitis.

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.

20d. INJURY OCCURRED While Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Charles S. Petty -

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/30/60

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial 10/3/60

Baltimore National

Balto., Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REG STRAR

24b. REGISTRAR'S SIGNATURE

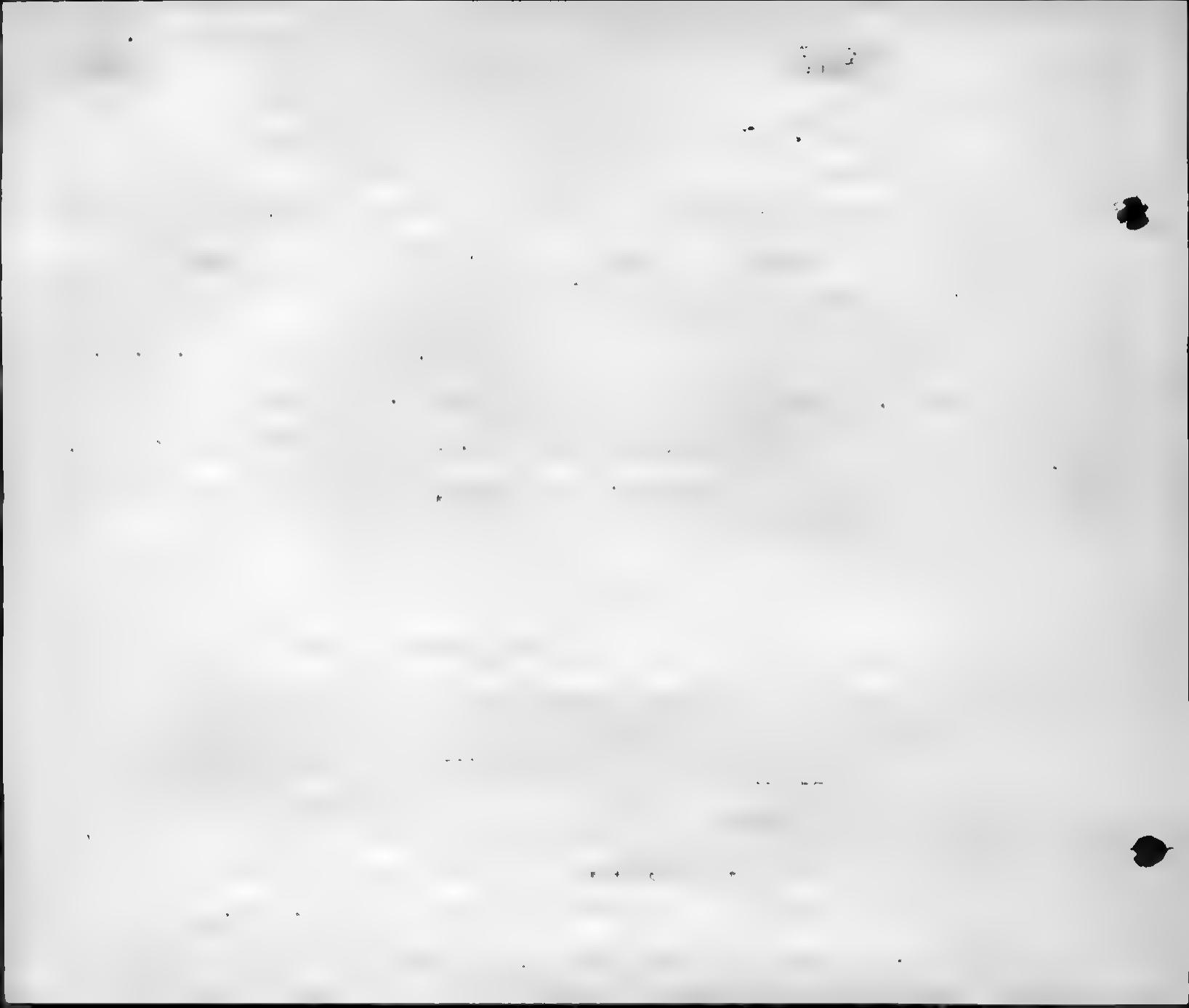
Howard H. Hubbard 4107 Wilkens Ave.

OCT 4 '60

Charles S. Petty

VS. A15ME
5M 7/59

Hans



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10042

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN TB 52 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville		d. STREET ADDRESS --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle B.	Last MILLER	4. DATE OF DEATH	Month September	Day 8	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH September 13, 1910	9. AGE (In years last birthday) 49 yrs	F UNDER 1 YEAR IF UNDER 24 HRS. Months 49	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin L. Miller				14. MOTHER'S MAIDEN NAME Annie Anthony			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 219-07-7101		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				WIDESPREAD ADENOCARCINOMA, PRIMARY UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 22 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 18, 1960 , to September 8, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 8, 1960 , and that death occurred at A. M. , from the causes and on the date stated above.						22b. DATE SIGNED 9/8/60	
22a. SIGNATURE Frederick S. Donaldson		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 8, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Centerville Cemetery		23d. LOCATION (City, town, or county) (State) Centerville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Barton Brothers Funeral Directors, Centerville, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE Loring J. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 filing 72 10-3-60 et

10706

10048

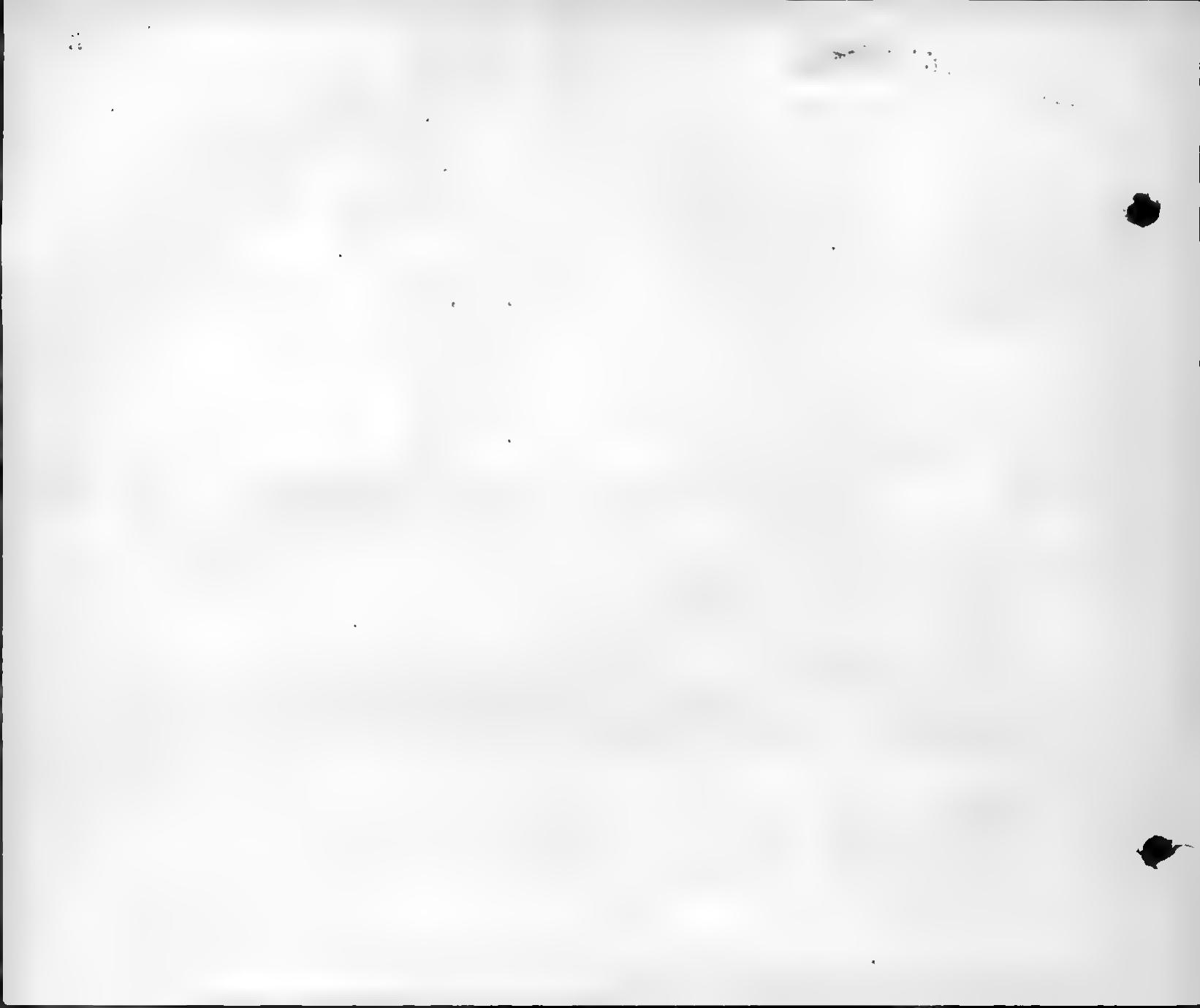
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		d. STREET ADDRESS 6700 Selkirk Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6700 Selkirk Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs. Barbara Minnick		First	Middle	Last	4. DATE OF DEATH September 27 1960	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1883	9. AGE (In years lost birthday) 76 1/4 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Jacob Janda		14. MOTHER'S MAIDEN NAME Anna Melicker						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alfred Chris		Address 6700 Selkirk Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		Carcinoma, bladder		Severe Anemia, bladder hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 mos		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 19 to Sept 27, 1960 , that I last saw the deceased alive on 9-25-1960 , and that death occurred at 11 A.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) Joseph F. Filipa 8405 North Haven St. Baltimore, Md.		DATE SIGNED 9/27/60		
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Joseph F. Filipa								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/60		22c. NAME OF CEMETERY OR CREMATORIAL Mortena Memorial		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 28 '60		24b. REGISTRAR'S SIGNATURE John S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



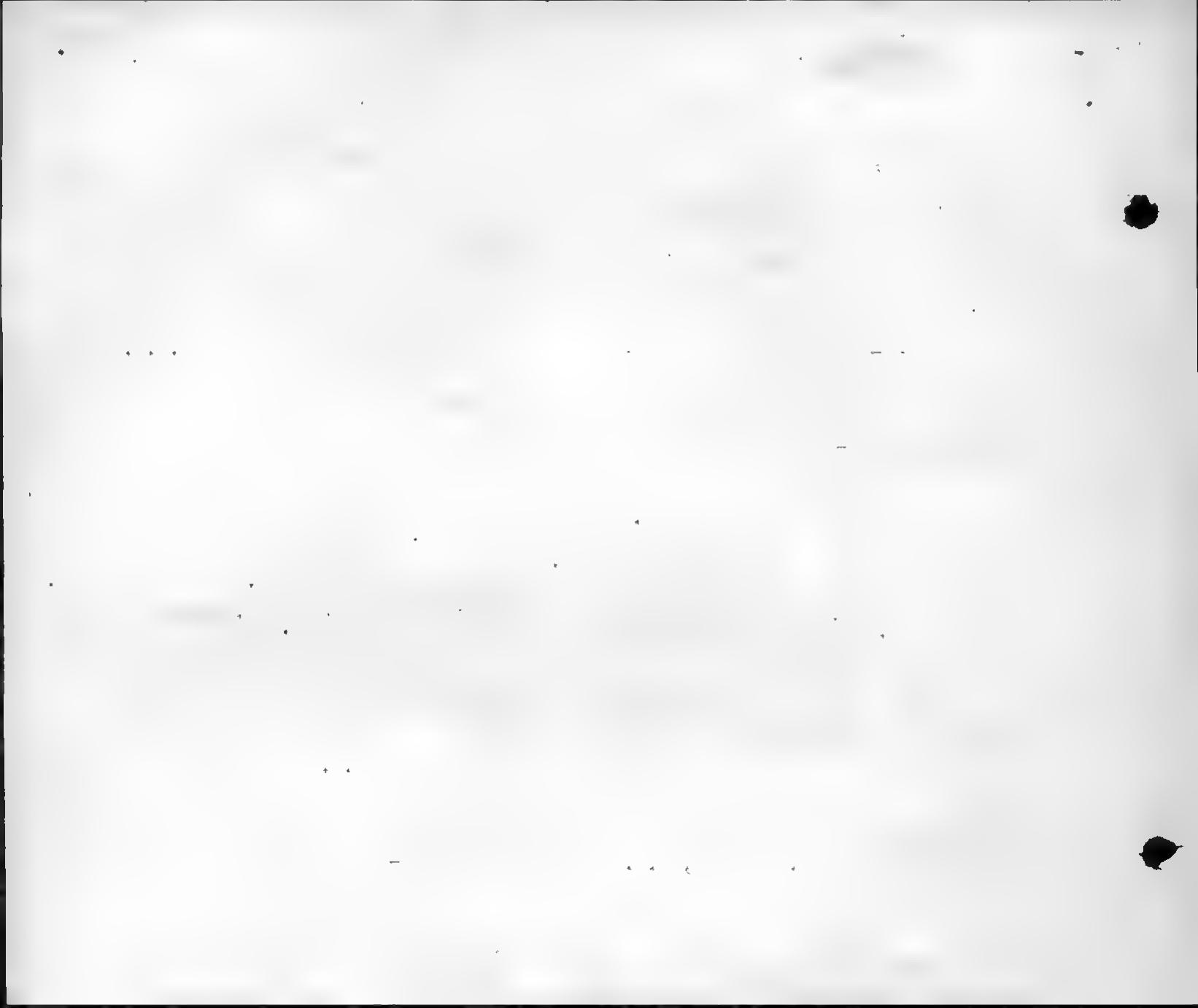
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10007

1. PLACE OF DEATH Rosewood State Training School o. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN lb 36-years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Rosewood State Training School			d. STREET ADDRESS 11123		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Phillip	Middle Beckwith	Last Mowbray	4. DATE OF DEATH	Month 9 Day 2 Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/3/16	9. AGE (In years last birthday) 44 yrs	IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Mowbray			14. MOTHER'S MAIDEN NAME Susie Mowbray		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Embolism, pulmonary, due to circulatory disturbance DUE TO suspected. INTERVAL BETWEEN ONSET AND DEATH 20-min. 460X Conditions if any which gave rise to immediate cause (a), stating the under lying cause last } (b) Thrombosis of vein of leg due to unspecified cause, suspected. } DUE TO cause, suspected. (c) Varicose veins of legs due to unknown cause. 10-yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN Edema of legs, dermatitis hypostaticum, recent prolonged bed rest. Elderly Mongoloid. Recent studies of heart, lungs, kidneys negative.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) —	
20f. (City or town) — (County) — (State) —					
21. I certify that (I) (this hospital) attended the deceased from 10/58 to 9/2/60 , 19, that (I) (we) lost the deceased alive on 9/2/60 . 19, and that death occurred of — M, from the causes and on the date stated above					
22a. SIGNATURE Edward J. Mathews		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/2/60	
22c. PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.		22d. ADDRESS Rosewood - Owings Mills, Maryland			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 2nd 1960		23c. NAME OF CEMETERY OR CREMATORIAL Bethesda Memorial Park Cemetery	
23d. LOCATION (City, town, or county, State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE La Compte Funeral Home Ambushy		ADDRESS —		25a. REC'D BY REGISTRAR DATE SEP 7 '60	
				25b. REG STRR'S SIGNATURE Arthur S. Knue	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10045

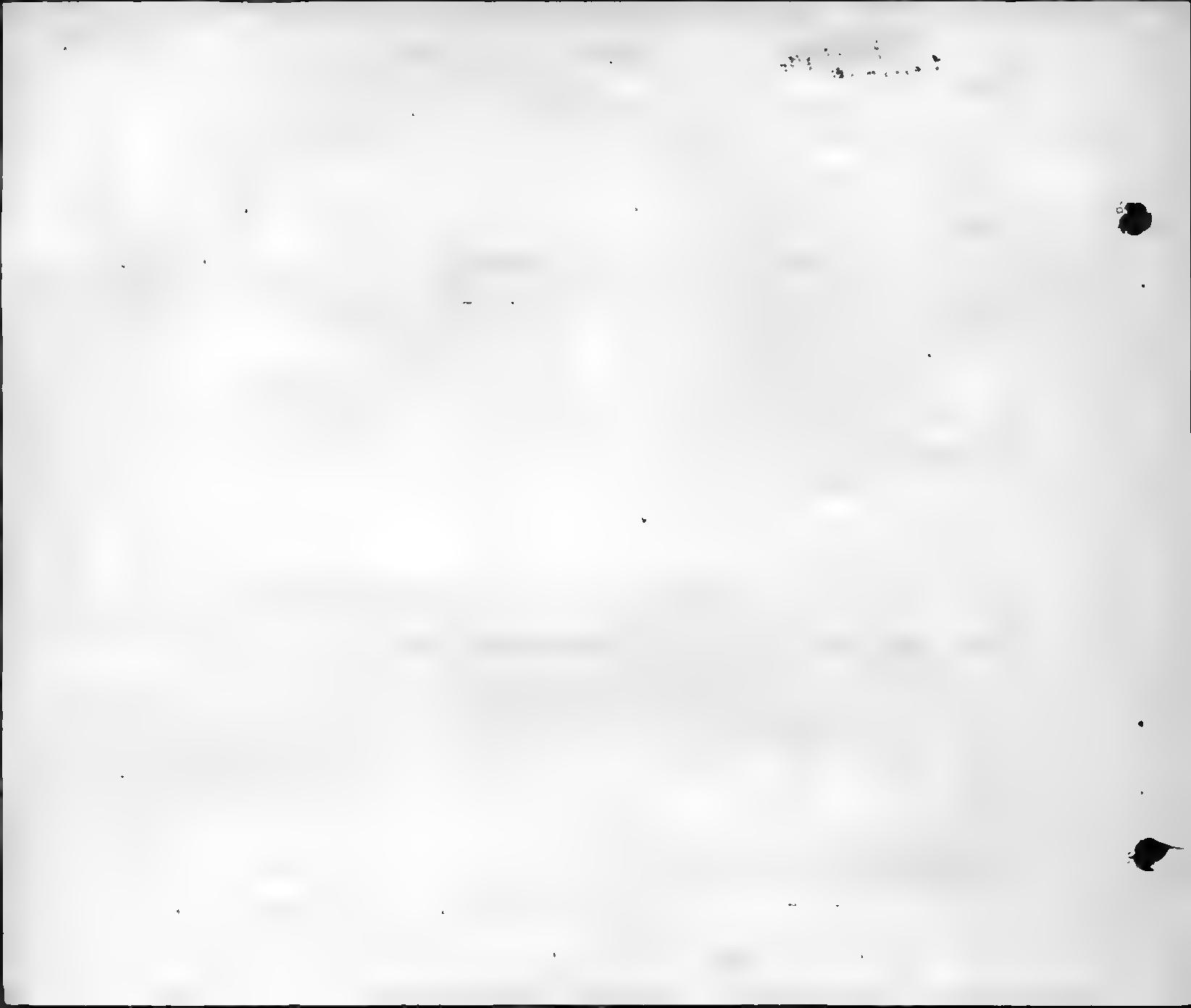
CERTIFICATE OF DEATH

10008

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should remain with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1657 Yakona Rd.		e. STREET ADDRESS 1657 Yakona Rd.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel	First S	Middle 	Last Muffoletto
4. DATE OF DEATH Sept. 13, 1960	Month Sept.	Day 13	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1876
9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 	Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stone Mason	10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Muffoletto	14. MOTHER'S MAIDEN NAME Rose (Unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	16. SOCIAL SECURITY NO. 	17. INFORMANT Mrs Rose Furnari	Address same
18. CAUSE OF DEATH: [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Hypertension cardio-macular de			INTERVAL BETWEEN ONSET AND DEATH 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) 	
		(State) 	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 		DATE SIGNED 	
ACTUAL SIGNATURE Ronald Jandorf M.D.			
PHYSICIAN'S NAME (Type) R Donald Jandorf			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-16-60	22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cem.	22d. LOCATION (City, town, or county) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE SEP 16 '60	24b. REGISTRAR'S SIGNATURE Charles S. Knue



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10046

CERTIFICATE OF DEATH

10009

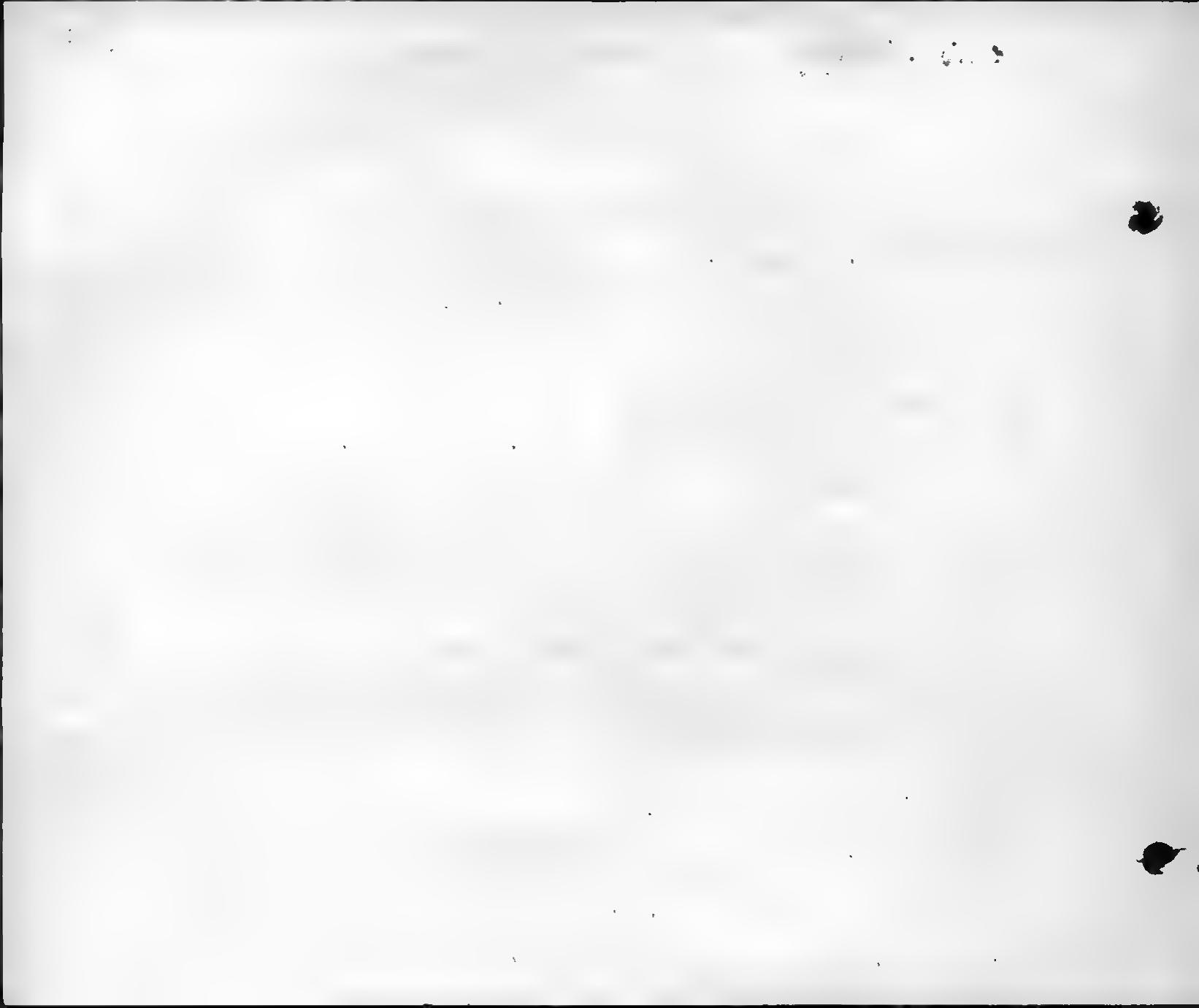
Reg. Dist. No.

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to be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

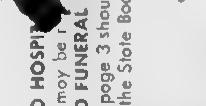
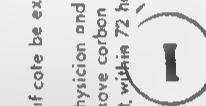
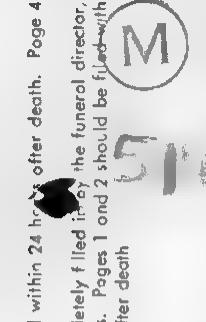
VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 525 Alleghany Avenue		d. STREET ADDRESS 525 Alleghany Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mrs. Rose H.	Middle Murray	Last September 21, 1960
4. DATE OF DEATH	Month September	Day 21	Year 1960
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1883
9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Harford Co. Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Martin Flavin		14. MOTHER'S MAIDEN NAME Johanna Welsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 217-36-4531	
17. INFORMANT Mrs. Margaret M. Rabel		Address 525 Alleghany Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Myocardial infarction DUE TO Congestive heart failure DUE TO Chronic bronchitis			
INTERVAL BETWEEN ONSET AND DEATH 1 week - 1 month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26/60 to 9/10/60 , 1960, that I last saw the deceased alive on 9/24/60 , 1960, and that death occurred at 11:00 AM from the causes and on the date stated above			
ACTUAL SIGNATURE George J. Gilmore		ADDRESS (Street, city or town, state) St. Joseph Cemetery, Texas, Maryland	
DATE SIGNED Sept 26 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/60	
22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery		22d. LOCATION (City, town, or county) Texas, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE SEP 26 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert be executed within 24 hrs after death. Page 4 may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10047

CERTIFICATE OF DEATH

10010

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3lyr4mth12dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 105 South High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ida	Middle OL SCHANSKY	Last OL SCHANSKY	4. DATE OF DEATH Sept. 14, 1960	Month Year 1960	Day Year 19	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20 1893		9. AGE (In years last b'rthday) 89 yrs 69 ^{rs}	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Warsaw Poland		12. CITIZEN OF WHAT COUNTRY? Poland		
13. FATHER'S NAME Louis Shir				14. MOTHER'S MAIDEN NAME Lena Silver				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial infarction (c) DUE TO Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1959, to Sept. 17, 1960, that (I) (we) last saw the deceased alive on Sept. 17, 1960, and that death occurred at 12 M, from the causes and on the date stated above.								
22a. SIGNATURE <i>L. M. LEVINSON</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. I. M. Levinson		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/60		23c. NAME OF CEMETERY OR CREMATORIAL Bet Jacob Vecair		23d. LOCATION (City, town, or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC		ADDRESS 6010 Reisterstown Rd.		25a. REC'D BY REGISTRAR DATE SEP 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
14. VR A15 14. 15M 9/59								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

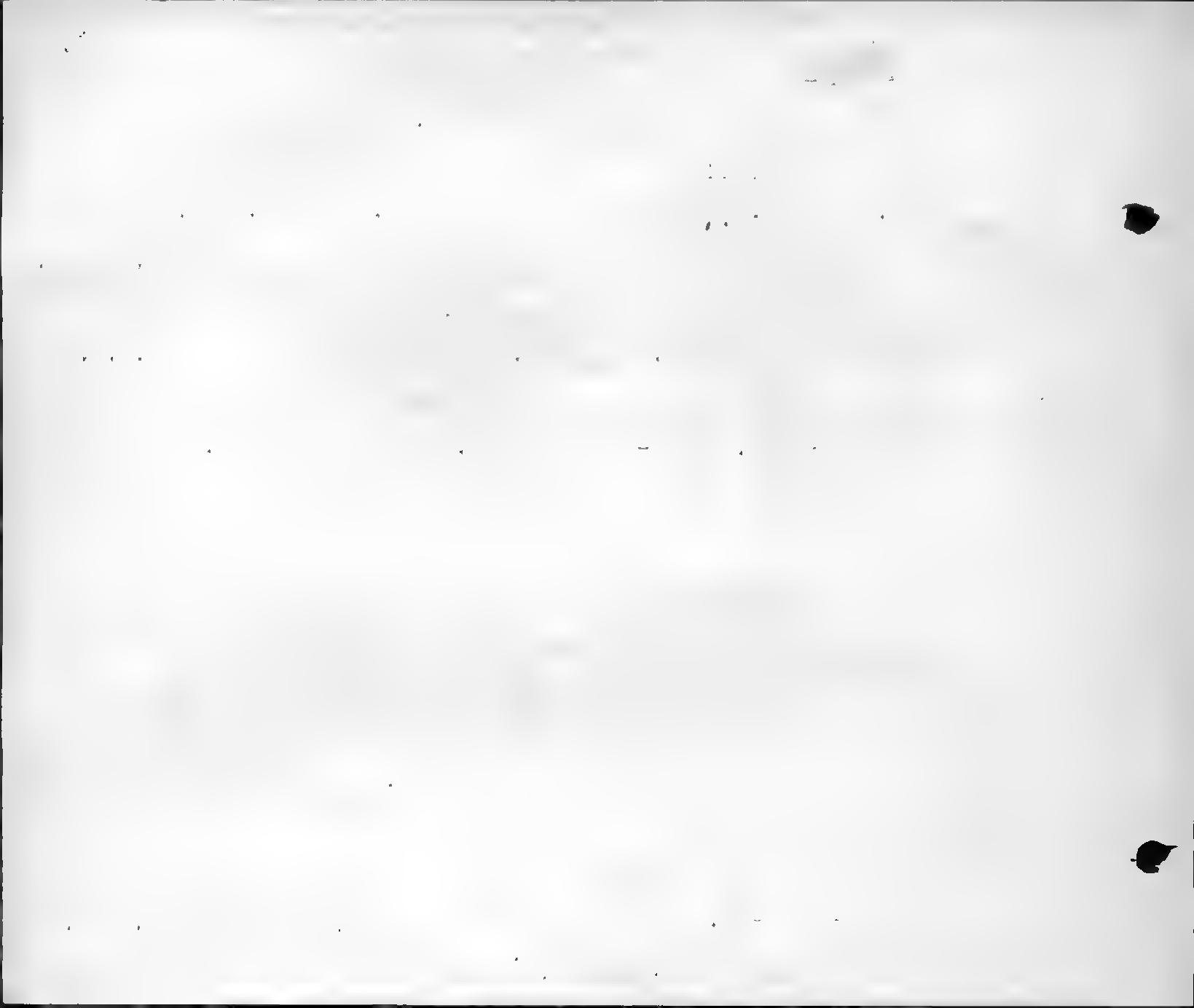
10048

CERTIFICATE OF DEATH

Reg. Dist. No.

10011

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbor View		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbor View					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 S. 48th St. # 24		d. STREET ADDRESS 507 S. 48th St. #24.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) TERJE		First	Middle	Last	4. DATE OF DEATH September 9, 1960.	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1889	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Trans.Co.		11. BIRTHPLACE (State or foreign country) Tromso, Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Carl Olsen		14. MOTHER'S MAIDEN NAME Betsy ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1912-1913.213-10-0938		17. INFORMANT Eva K. Olsen		Address Same.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH DUE TO 6 days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio Sclerosis 10 years. DUE TO (c) Hypertension 10 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 7225 Eastern Blvd.		(County) Md.	(State) Md.
21. I certify that I attended the deceased from May 1952 to Sept 9, 1960 that I last saw the deceased alive on Sept 9, 1960 , and that death occurred on 11:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 North Point Rd Baltimore Md. DATE SIGNED 10/13/60							
PHYSICIAN'S NAME (Type) Morris A. Jacobs									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12 -60.		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) 7225 Eastern Blvd.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Seiler		ADDRESS 6224 Eastern Ave. Balto., Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Collins & Hanna			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10049

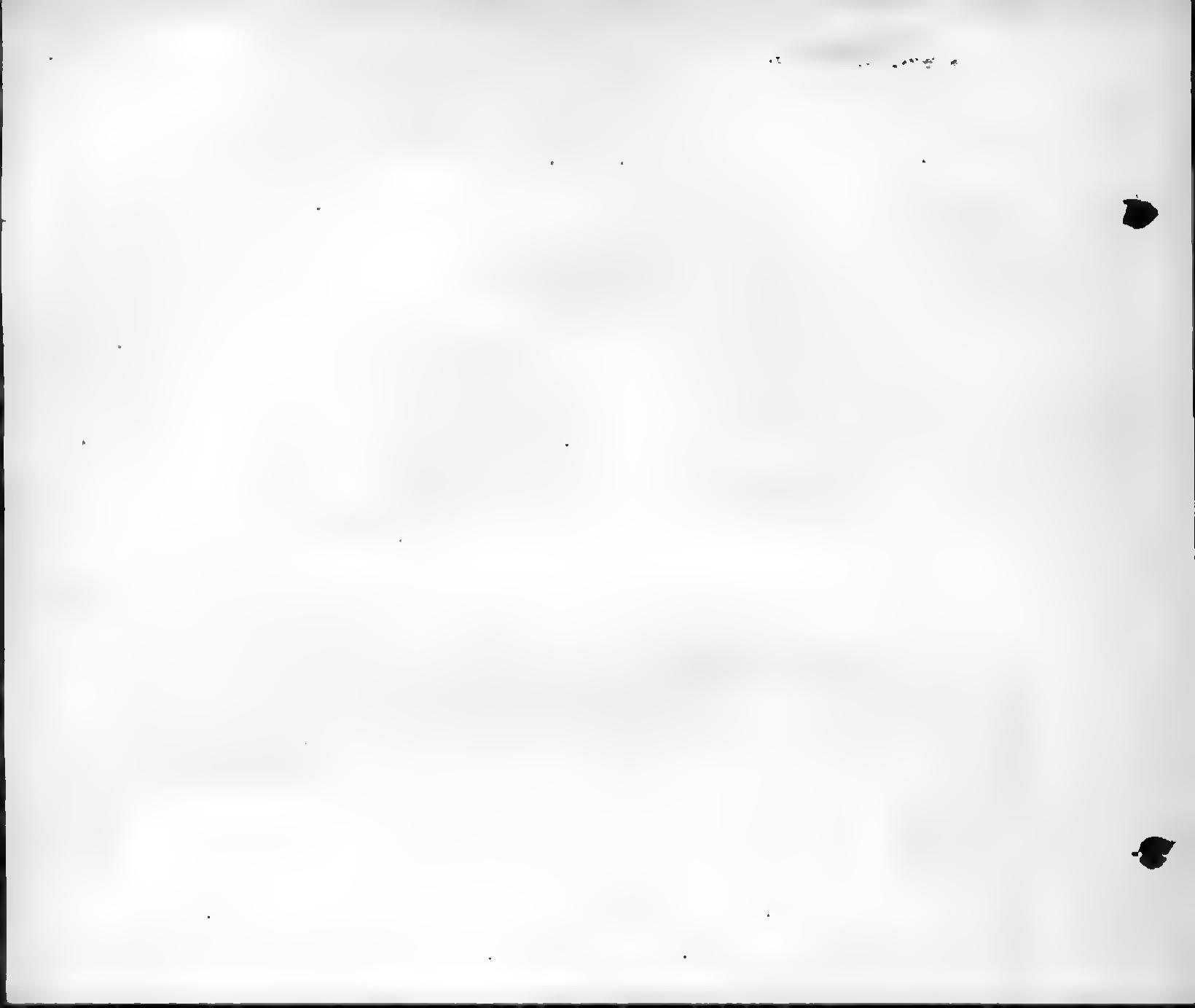
10012

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		Rosewood State Training School MARYLAND		12. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Wings Mills Md.		c. LENGTH OF STAY IN 1b 2 yrs. 6 mo.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 8 Regester Ave.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Varian	Last O'Neill	4. DATE OF DEATH 3-11-58	Month 9	Day 17	Year 1960
S. SEX Female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-58	9. AGE (In years last birthday) 2 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Maurice Thomas O'Neill		14. MOTHER'S MAIDEN NAME Judith Daly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood Records		Address O'Wings Mills Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 52 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Congenital internal hydrocephalus, marked							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>4-9</u> <u>1960</u> to <u>9-17</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>9-17</u> <u>1960</u> , and that death occurred at <u>11A</u> st , from the causes and on the date stated above.							
22a. SIGNATURE <u>Peter W. Rieckert</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4-18-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		22d. ADDRESS <u>4307 Mainfield Ave., Baltimore</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19. 1960		23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		23d. LOCATION (City, town or county) Baltimore Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS. INC. Baltimore Md.				25a. REC'D BY REGISTRAR DATE SEP 20 '60		25b. REGISTRAR'S SIGNATURE <u>Clara L. Stinson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10013

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, or removal.

VS. A15ME(S)
SM 9/55

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b in transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
3. NAME OF DECEASED (Type or print) Noah		First Peterson	Middle Last Peterson
4. DATE OF DEATH Sept. 17 Year 1960	Month Sept.	Day 17	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1941
9. AGE (In years months/ days) 19 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asplundh Tree Triner		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Floyd L. Peterson		14. MOTHER'S MAIDEN NAME Mamie Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs. Mamie Peterson	Address Reisterstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severed rt. jugular vein, larynx, trachea</i> <i>025X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) car moving S. bound, jumped curb & struck side of building.	
20c. TIME OF INJURY Hour 1:05 pm	Month, Day, Year 9-17-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Main St. 20f. (City or town) Reisterstown, Balto., Md. (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-17-60
EXAMINER'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 20, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Memorial Gardens	22d. LOCATION (City, town, or county) Pinksburg (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	24a. REC'D BY REGISTRAR SEP 20 60 DATE
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Friend</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

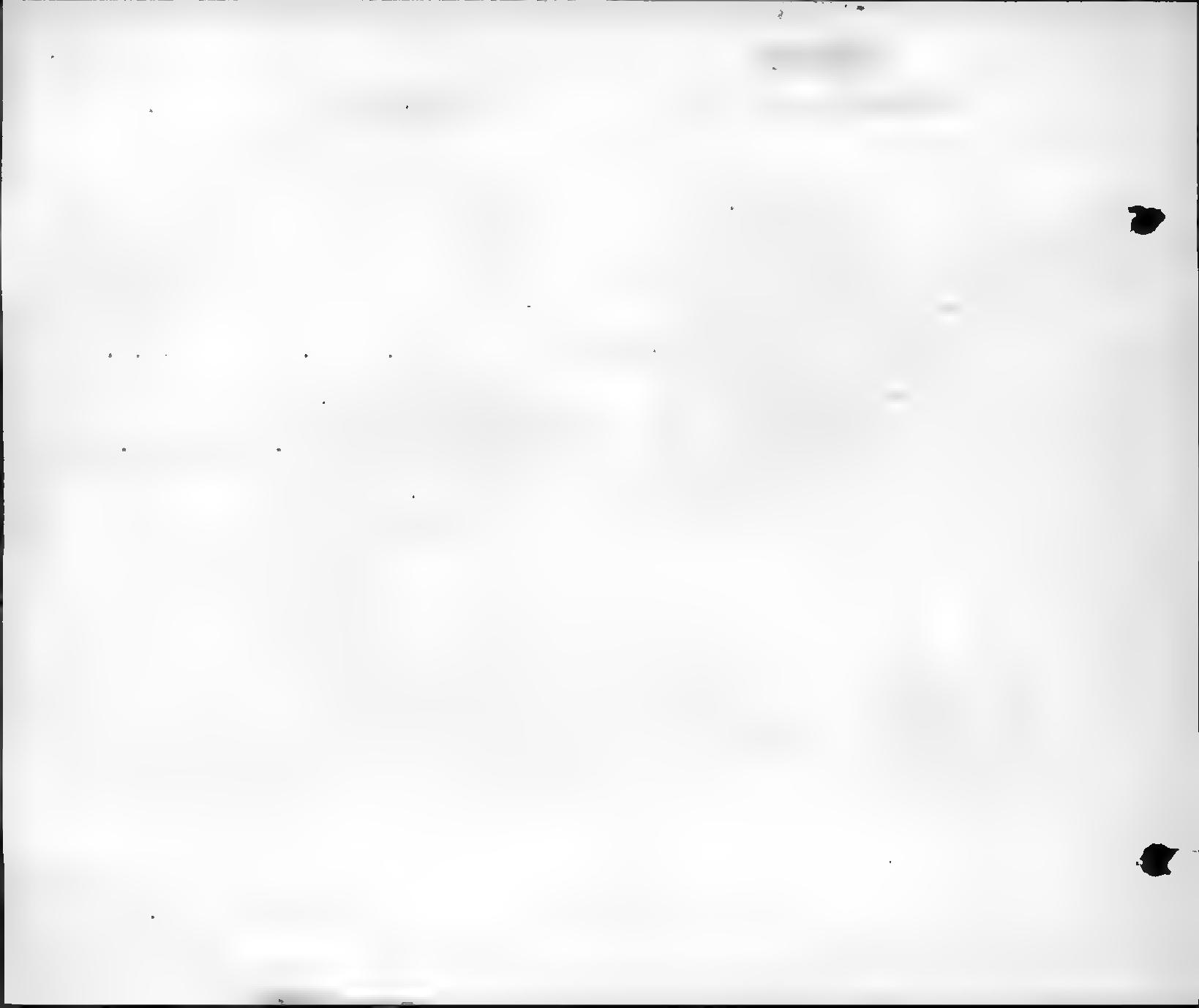
CERTIFICATE OF DEATH

Reg. Dist. No. 10014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

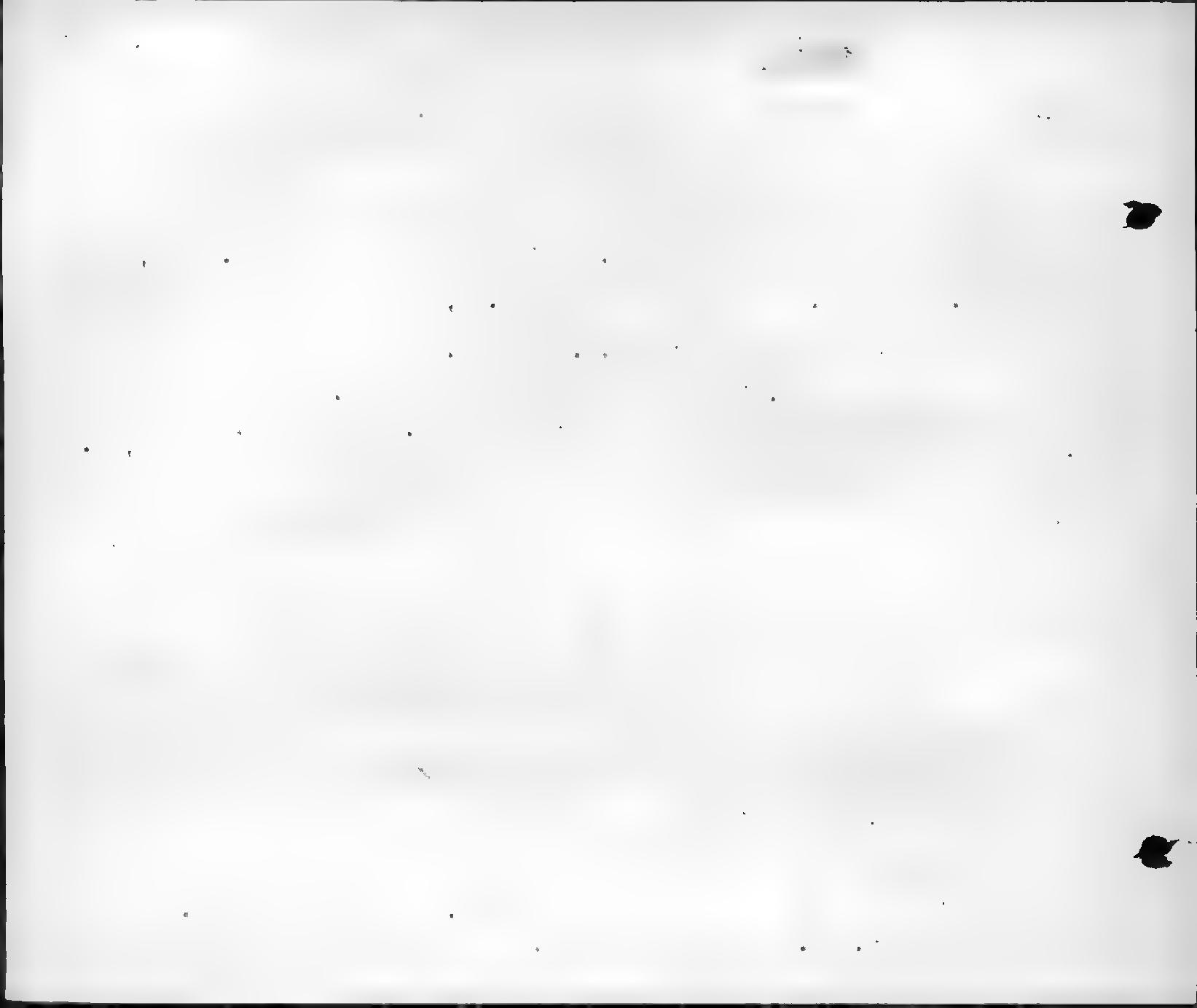
1. PLACE OF DEATH o COJ Cockeysville Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE o. STATE Cockeysville b. CITY b. CITY BALTO. MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.	d. STREET ADDRESS Warren Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Walter	First	Middle	Last
4. DATE OF DEATH 9-- 29	Month	Day	Year 19 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY selfemployed	
10c. BIRTHPLACE (State or foreign country) Balto., Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Emma Peterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Grayson Peterson, Sr. Warren Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ARTERIOSCLEROTIC CEREBRAL INFARCT DISEASE 6 yrs (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town state) ACTUAL William A. Pillsbury M.D. 2000 York Rd., Timonium, Md. 5-23-60			
DATE SIGNED			
PHYSICIAN'S NAME (Type) William A. Pillsbury, M.D.			
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-1960	
22c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove		22d. LOCATION (City, town, or county) Cockeysville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral service		24a. REC'D BY REGISTRAR DATE OCT 4 '60	
ADDRESS 622 York Rd-4-		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												10015	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Life				b. COUNTY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 Beaumont Ave				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Thomas				First	Middle	Last	4. DATE OF DEATH Sept. 22, 1960	Month	Day	Year			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 27, 1877	9. AGE (In years lost birthday) yrs. 83	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Repairman B & O R.R.				10b. KIND OF BUSINESS OR INDUSTRY Md.				11. BIRTHPLACE (State or foreign country) USA					
13. FATHER'S NAME James M. Pitcher				14. MOTHER'S MAIDEN NAME Margaret A. Key									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO				17. INFORMANT Mrs Ralph M. Crawford Sr. 221 Beaumont Ave, Catonsville 28, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				<i>Coronary artery disease</i>				INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO (b) DUE TO (c)	<i>Generalized arterio-arteric End. Dis</i> <i>10 yrs</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m.		Month Sept. 22	Day 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pikesville	(County) Md.	(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1960 , to Sept. 22, 1960 , that (I) (we) last saw the deceased alive on Sept. 22, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above												22b. DATE SIGNED 9/22/60	
22c. SIGNATURE <i>J. Nelson McKay</i>				M.D. ATTENDING PHYS ✓ MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 6014 Edmondson Ave.								
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/60	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery				23d. LOCATION (City, town, or county) Pikesville Md.						
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.				ADDRESS 4101 Edmondson Ave.	25a. REC'D BY REGISTRAR DATE SEP 26 '60				25b. REC'D BY REGISTRAR'S SIGNATURE C. Witzke				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

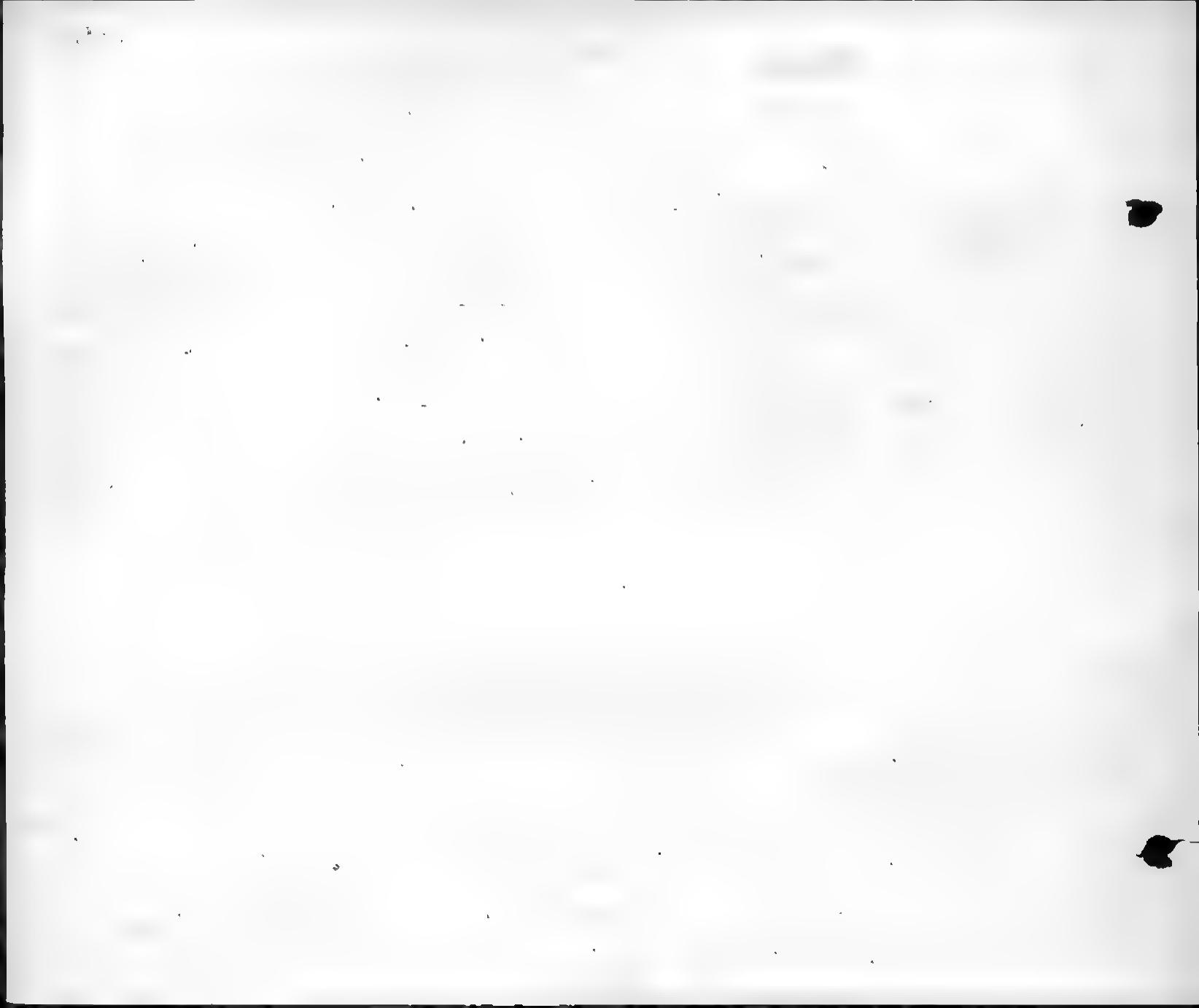
CERTIFICATE OF DEATH

Reg. Dist. No. 10316

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>P</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>		c. LENGTH OF STAY IN TB <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2516 Joppa Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>	
3. NAME OF DECEASED (Type or print) <i>Gertrude</i>		First <i>Mary</i>	Middle <i></i>
3. NAME OF DECEASED (Type or print) <i>Gertrude</i>		Last <i>Plecker</i>	4. DATE OF DEATH <i>Sept. 9 1960</i>
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>12/16-1897</i>		9. AGE (In years last birthday) <i>62</i>	10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Patrick Sheridan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cowan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	INFORMANT <i>Samuel Plecker</i>
		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>17</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>			
DUE TO <i>(c) Carcinoma of ovary</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>18 mo.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) <i></i> (State) <i></i>
21. I certify that I attended the deceased from <i>Jan 6, 1959</i> , to <i>Sept. 9, 1960</i> that I last saw the deceased alive on <i>Sept. 6, 1960</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>M.D. 8100 Harford Rd.</i>			
ACTUAL SIGNATURE <i>J.A. Grotto</i>		DATE SIGNED <i>9/9/60</i>	
PHYSICIAN'S NAME (Type) <i>H.A. GROTT, MD.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>9-12-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Mem.</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 13 '60</i>	24b. REGISTRAR'S SIGNATURE <i>L. J. Ruck</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

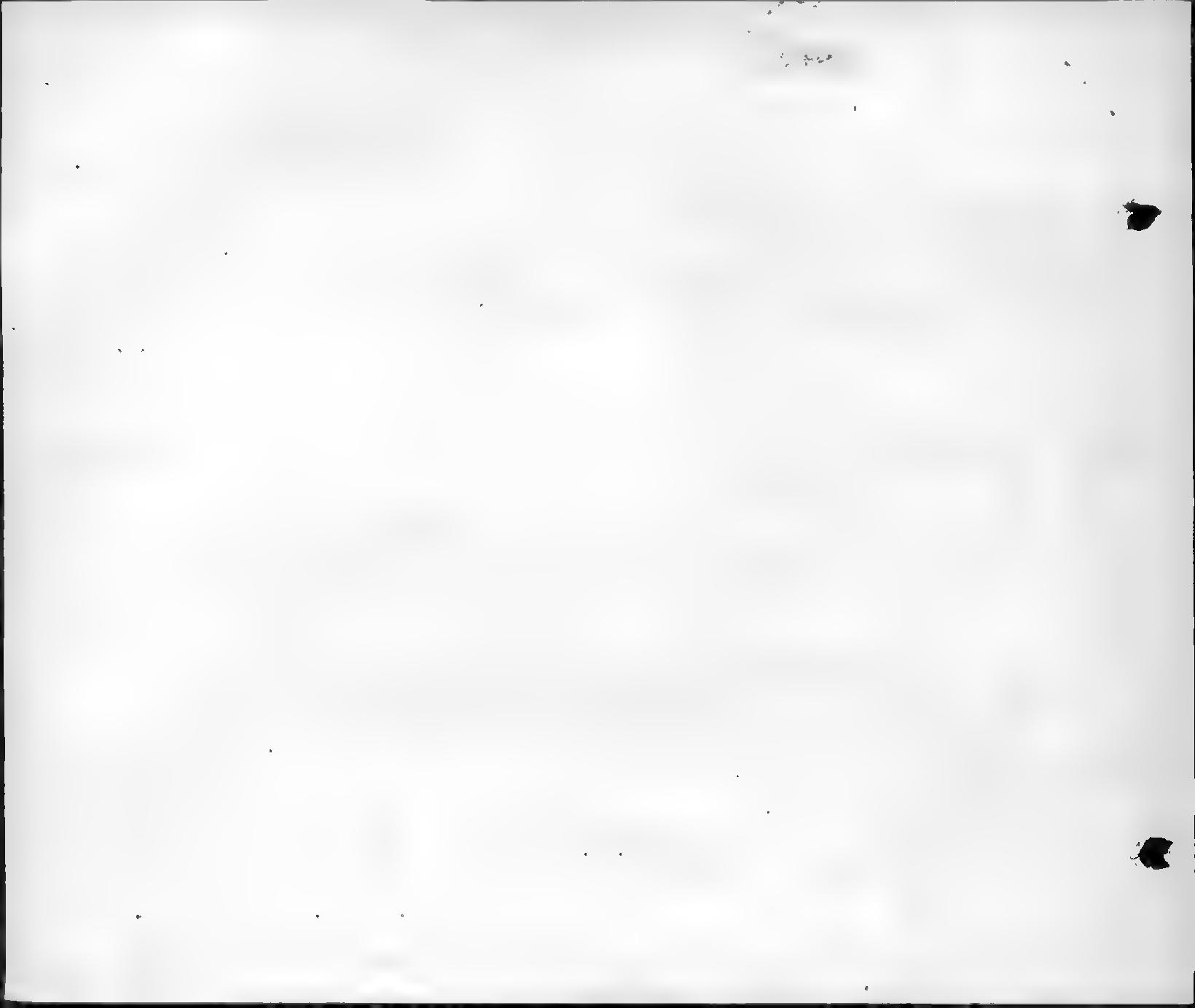
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10052

CERTIFICATE OF DEATH

10017

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND	2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission o. STATE Maryland	b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gatonsville		c LENGTH OF STAY IN lb Pyrlunth 27dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa Maryland (Edgewood, Md.)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 12 - 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Leura	Middle Jane	Last Poole	4 DATE OF DEATH Month September Day 5 Year 9 60	
S SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1875	9 AGE in years 84 last birthday yrs.	10 IF UNDER 1 YEAR Months 84 Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert Carico			14. MOTHER'S MAIDEN NAME Caroline Cox		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
Address					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease					
INTERVAL BETWEEN ONSET AND DEATH					
422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arteriosclerosis (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 8, 1958, to Sept. 5, 1960, that (I) (we) last saw the deceased alive on Sept. 5, 1960, and that death occurred at 8:20 p. m., from the causes and on the date stated above.					
22a SIGNATURE Stella Wachsler		ATTENDING PHYS <input type="checkbox"/> M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 9-6-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL GATONSVILLE 28, Maryland			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 9/8/60		23c NAME OF CEMETERY OR CREMATORIAL Oak Grove Baptist Cem.	
24 FUNERAL DIRECTOR'S SIGNATURE John G. Farries		ADDRESS John G. Farries		25a. REC'D BY REGISTRAR DATE SEP 8 '60	
				25b. REGISTRAR'S SIGNATURE John G. Farries	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10018

Reg. Dist. No.

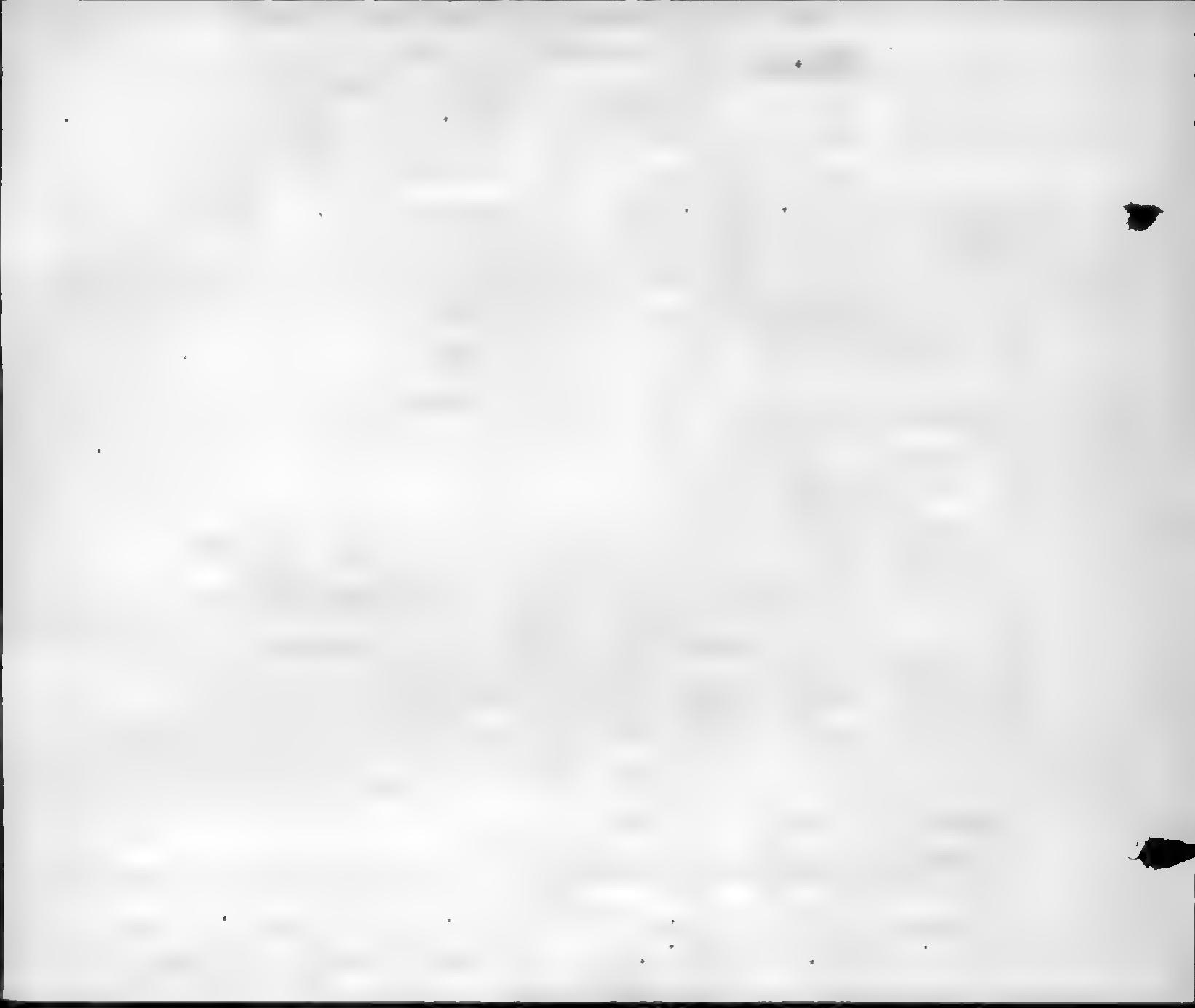
10018-3

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 209 Riverside Dr. Balto. 21		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Riverside Dr. Balto. 21				d. STREET ADDRESS 209 Riverside Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AGATHA POWICHROSKI (POWICHROWSKI)		First	Middle	Last	4. DATE OF DEATH September 26	Month	Day	Year 1960
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1-30-1888	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Baron		14. MOTHER'S MAIDEN NAME Unknown		Address Edward Powichroski 7955 Eastdale Rd.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH 3 mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. [b] DUE TO [c]		Carcinoma of lung						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Sept 24, 1960						
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore (State) Md.
21. I certify that I attended the deceased from Sept 24, 1960 to Sept 26, 1960 that I last saw the deceased alive on Sept 24, 1960 , and that death occurred at 1:40 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Joseph Miceli M.D. 108 S. Taylor Ave 7/27/60		DATE SIGNED 7/27/60
ACTUAL SIGNATURE <i>Joseph Miceli M.D.</i>								
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D. Baltimore 21 Md								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/1960		22c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus Cem.		22d. LOCATION (City, town, or county) Baltimore Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc.		ADDRESS 401 S. Chester St.		24a. REC'D BY REGISTRAR SEP 28 '60		24b. REGISTRAR'S SIGNATURE <i>Loring H.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Form 271 9-26060 et

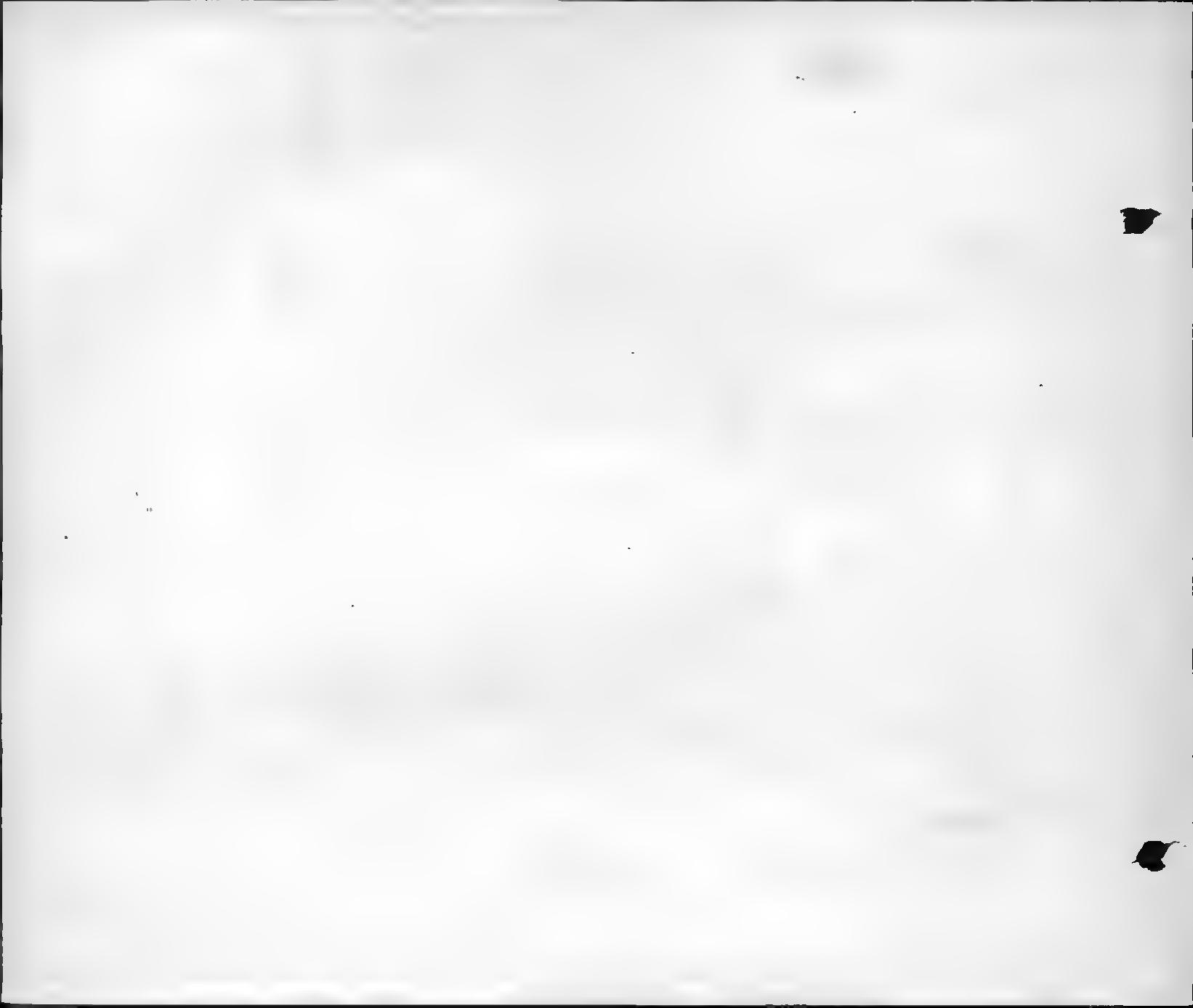
10054

CERTIFICATE OF DEATH

Reg. Dist. No.

10019

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	c. LENGTH OF STAY IN 1b <i>12 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Warren Road</i>	d. STREET ADDRESS <i>Warren Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Samuel M. Price</i>	First	Middle	Last
4. DATE OF DEATH <i>September 14 1960</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 1890</i>
9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Former</i>	
10c. BIRTHPLACE (State or foreign country) <i>Sports Balt Co. Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Emory Price</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Wheeler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-3108</i>	
17. INFORMANT <i>Wife</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardiac failure</i> <i>arterio sclerotic cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1950</i> to <i>September 1960</i> , that I last saw the deceased alive on <i>138 Plaza Rd</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter T. Kees M.D.</i>		ADDRESS (Street, city or town, state) <i>Cockeysville 14 Sept 1960</i> DATE SIGNED <i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9-17-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>JESSOP OEM.</i>		22d. LOCATION (City, town, or county) <i>COCKEYSVILLE - MD</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. McCook-Towson - York Rd - Towson</i>		24a. REC'D BY REGISTRAR DATE <i>SEPT 16 60</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Turner</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

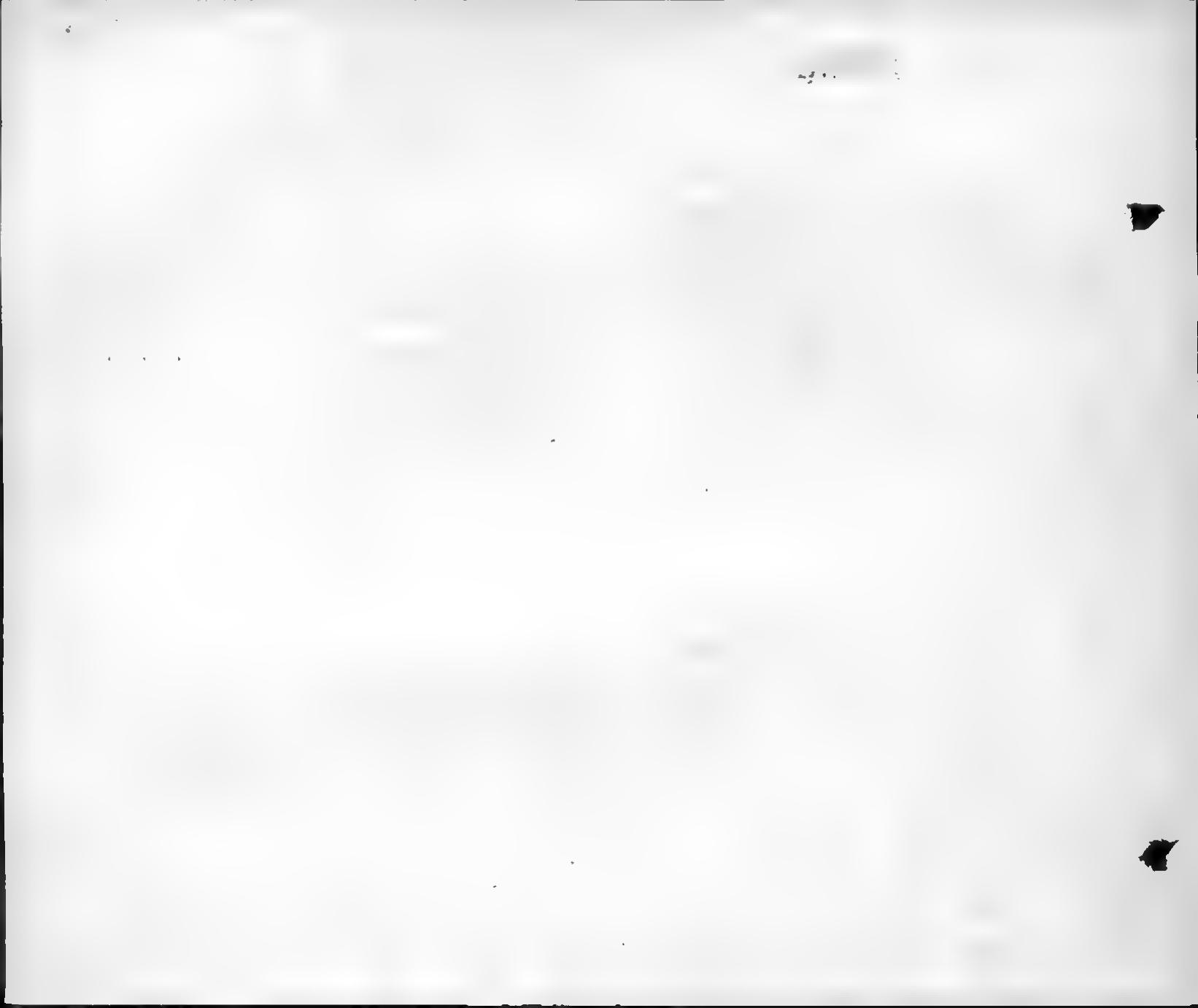
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10020

10020																
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23 yr/mthldys			d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Warrie		First		Middle		Last		4. DATE OF DEATH Pritchett		Month		Day		Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1881		9. AGE (in years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night watchman				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME George Pritchett					14. MOTHER'S MAIDEN NAME Unknown					Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown					16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records : SPRING GROVE STATE HOSPITAL			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 605 X (b) Bilateral pyelonephritis DUE TO (c) Urinary cystitis					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from July 25, 1960 to Sept. 18, 1960 , that (I) (we) last saw the deceased alive on Sept. 18, 1960 , and that death occurred at p. M. from the causes and on the date stated above					22e. SIGNATURE Stella Wachsler, M. D.					22b. DATE SIGNED 9-19-60						
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.					22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					23a. BURIAL CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 9/21/60 23c. NAME OF CEMETERY OR Crematory OAK LAWN 23d. LOCATION (City, town, or county) Balto. Co. Md.						
24. FUNERAL DIRECTOR'S SIGNATURE G.W. Hoffmann					ADDRESS 3218 Hudson St.					25a. REC'D BY REGISTRAR DATE SEP 20 '60					25b. REG. STRR'S SIGNATURE Clifford S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the physician may be retained by the hospital or attending physician, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10021

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) b. STATE	
BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
f. STREET ADDRESS 1209 DRUID HILL AVENUE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROLAND		First M	Middle PURVIANCE
4. DATE OF DEATH September 16 1960		Month September	Day 16
5. SEX MALE		6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH SEPT 8 1894		9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY THEATER	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PETER PURVIANCE	
14. MOTHER'S MAIDEN NAME HANNAH JANE JOHNSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) YES WW-I	
16. SOCIAL SECURITY NO 218-09-4451		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
45 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		HEART FAILURE	
DUE TO (b)		ARTERIOSCLEROSIS	
DUE TO (c)		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension; Chronic Renal Disease; Uremia; Electrolyte Imbalance; Possible Right Lung Tumor		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from September 7 1960 to September 16 1960 that (X) (we) last saw the deceased alive on Sept. 16 1960, and that death occurred at 6:10 p.m., from the causes and on the date stated above.		22a. SIGNATURE <i>Charles Allen, M.D.</i>	
22c. PHYSICIAN'S NAME (Type) Charles Allen, M.D.		22b. DATE SIGNED 9-17-60	22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-21-60	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTIMORE NATIONAL	23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE HEMSLEY FUNERAL HOME		25a. REC'D BY REGISTRAR DATE SEP 19 1960	25b. REGISTRAR'S SIGNATURE <i>Charles S. Hemsley</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

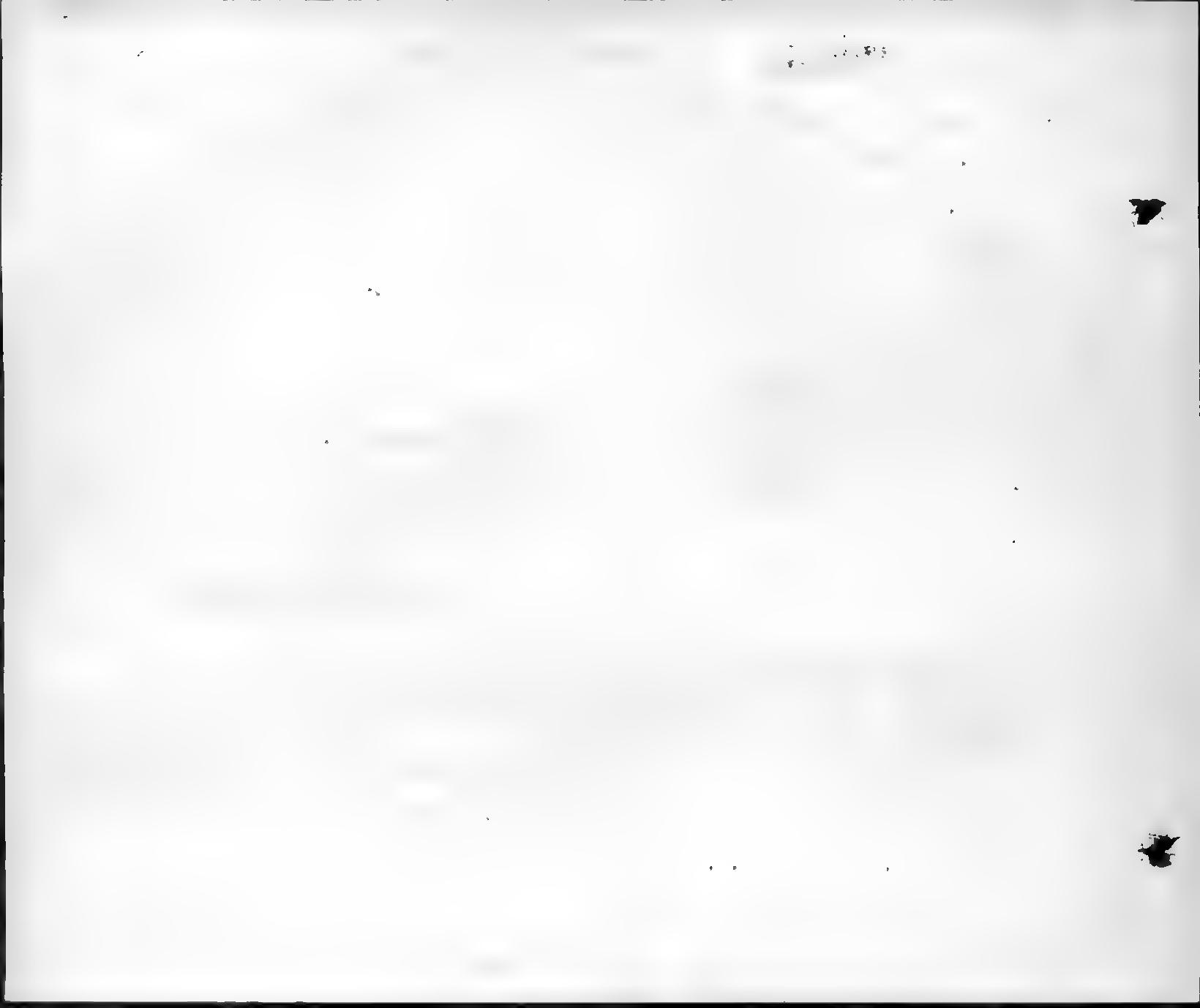
10022

100.57

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		b. COUNTY Harford				
c. LENGTH OF STAY IN 1b 9 mo. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 321 Hazzard St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Edward.	Middle	Last Pyle			
4. DATE OF DEATH	Month 9	Day 25	Year 1960			
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1898			
9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Md			
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Joseph Pyle	14. MOTHER'S MAIDEN NAME Julia Martin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 218-05-6057	INFORMANT	Address			
17. Hospital Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH 4 yrs.						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO				
{		DUE TO				
(c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pypleville	(County) Md.	(State) MD
21. I certify that I attended the deceased from 11/27, 1954 , to 9/25, 1960 , that I last saw the deceased alive on 9/25, 1960 , and that death occurred at 12:40 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		DATE SIGNED
ACTUAL SIGNATURE William Newcomer						
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/27/60	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul	22d. LOCATION (City, town, or county) Pypleville Md.			(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Murphy	ADDRESS Jessettville	24a. REC'D BY REGISTRAR DATE SEP 27 '60	24b. REGISTRAR'S SIGNATURE Charles E. Murphy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												10023					
10058 CERTIFICATE OF DEATH												Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY Baltimore											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex 21			d. STREET ADDRESS 206 Homberg Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Homberg Ave.																	
3. NAME OF DECEASED (Type or print) FRANCES RAYNER		First		Middle		Last		4. DATE OF DEATH Sept. 26,		Month		Day		Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1888		9. AGE (In years at death) 72 yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. CIVIL STATUS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Henry Ott						14. MOTHER'S MAIDEN NAME Elizabeth Futch						Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No						16. SOCIAL SECURITY NO 219-03-2593		17. INFORMANT Helen Long									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 463.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO						Coronary Occlusion arteriosclerotic Cardio Vascular disease Sudden 5 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Baltimore			(County)		(State)			
21. I certify that I attended the deceased from Jan. 1, 1960, to 9/26, 1960, that I last saw the deceased alive on 9/26, 1960, and that death occurred at 7 P.M., from the causes and on the date stated above.												ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE GMBaumgardner M.D.												DATE SIGNED 9/27/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/60		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery			22d. LOCATION (City, town, or county) Baltimore Maryland			(State)							
23. FUNERAL DIRECTOR'S SIGNATURE James Henry Baumlinski 407 Eastern Ave.						ADDRESS		24a. REC'D BY REGISTRAR Sep 29 '60		24b. REGISTRAR'S SIGNATURE C. E. K.							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10024

10024

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7909 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MAGGIE	Middle Reider	Last SeptemBer 27 1960
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH Jan. 21, 1872
8. AGE (In years at birth) 88 yrs		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Besold		14. MOTHER'S MAIDEN NAME Amelia Wildberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Millard Schilbach		Address 2228 E. Madison St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.1. X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Pulmonary Edema 2 days	
(b) DUE TO Cardio-Vascular Hypertensive Disease		1/2 years	
(c) DUE TO Arteriosclerosis		1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 1948 to SEPT. 27, 1960, that I last saw the deceased alive on SEPT. 26, 1960, and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Michael J. Darsch		M.D. 4636 Belair Road, Balt., Md. 9/27/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Parkwood		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Tassafin Funeral Home		ADDRESS 7401 Belair Rd.	
		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
		24b. REGISTRAR'S SIGNATURE C. L. Clark	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10026

Reg. Dist. No.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlt. St.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilkins S		d. STREET ADDRESS 5007 Wilkins Ave		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5007 Wilkins Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John L. Reuschling		First J	Middle L	Last Reuschling	4. DATE OF DEATH Dec. 14, 1960	Month Dec.	Day 14	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1904		9. AGE (in years Year of birthday) 56	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Reuschling		14. MOTHER'S MAIDEN NAME Olia Albright						
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 27-1100		17. INFORMANT Annie Reuschling		Address 5007 Wilkins Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) Supplementary circulatory disease DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year Dec. 14, 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE S. M. Kieffer	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Sept. 14, 1960	
EXAMINER'S NAME (Type) S. M. Kieffer M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/19/60	22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE HOWARD N. Hubbard	ADDRESS 5007 Wilkins Ave	24a. REC'D BY REGISTRAR SEP 19 '60	24b. REGISTRAR'S SIGNATURE C. G. Kraus					

TO H.
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4
the State Board of Health prior-to burial, cremation, or removal, and in any event, after 48 hours.

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y the funeral director,
should be filed with
1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10060

10027

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

EDWARD RHODE

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore County
Baltimore - 29
608 Orpington Rd.

2 DATE OF DEATH

Sept. 5, 1960

4. USUAL RESIDENCE (Where deceased lived if institution residence before admission)

a. STATE

b. COUNTY

Md.

Baltimore

c. CITY OR TOWN

(If outside city limits write RURAL and give township)

d. STREET ADDRESS

(If rural, give location)

608 Orpington Rd.

5. SEX 6 COLOR OR RACE
male white7 SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (In years
last birthday)

Nov. 9, 1877

82

If Under 1 Year
Months Days Hours Min.10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
(if retired))
Manager (self emp.)

10. B. KIND OF BUSINESS OR INDUSTRY

Real Estate

13 FATHER'S NAME

Martin Rhode

15 Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL SECURITY NO.
none

14. MOTHER'S MAIDEN NAME

Margaretha Shuster

17. INFORMANT

ADDRESS

Dr. C. Martin Rhode V.A.Hosp. Augusta, Ga.

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

10 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LASTII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES

22. I certify that (I) (this hospital) attended the deceased from Oct. 19.50 to
Sept. 19.60 that (I) last saw the deceased alive on Sept. 2. 19.60.

and that in (my) (our) opinion death occurred at 11:45 A.M. from the causes and on the date stated above.

23A. SIGNATURE *Leo J. Gaver*

23B. ADDRESS

1 Mallow Hill Ave.,
Baltimore 29, Md.

23C. DATE SIGNED

9/6/60

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M. D.24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORIAL

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

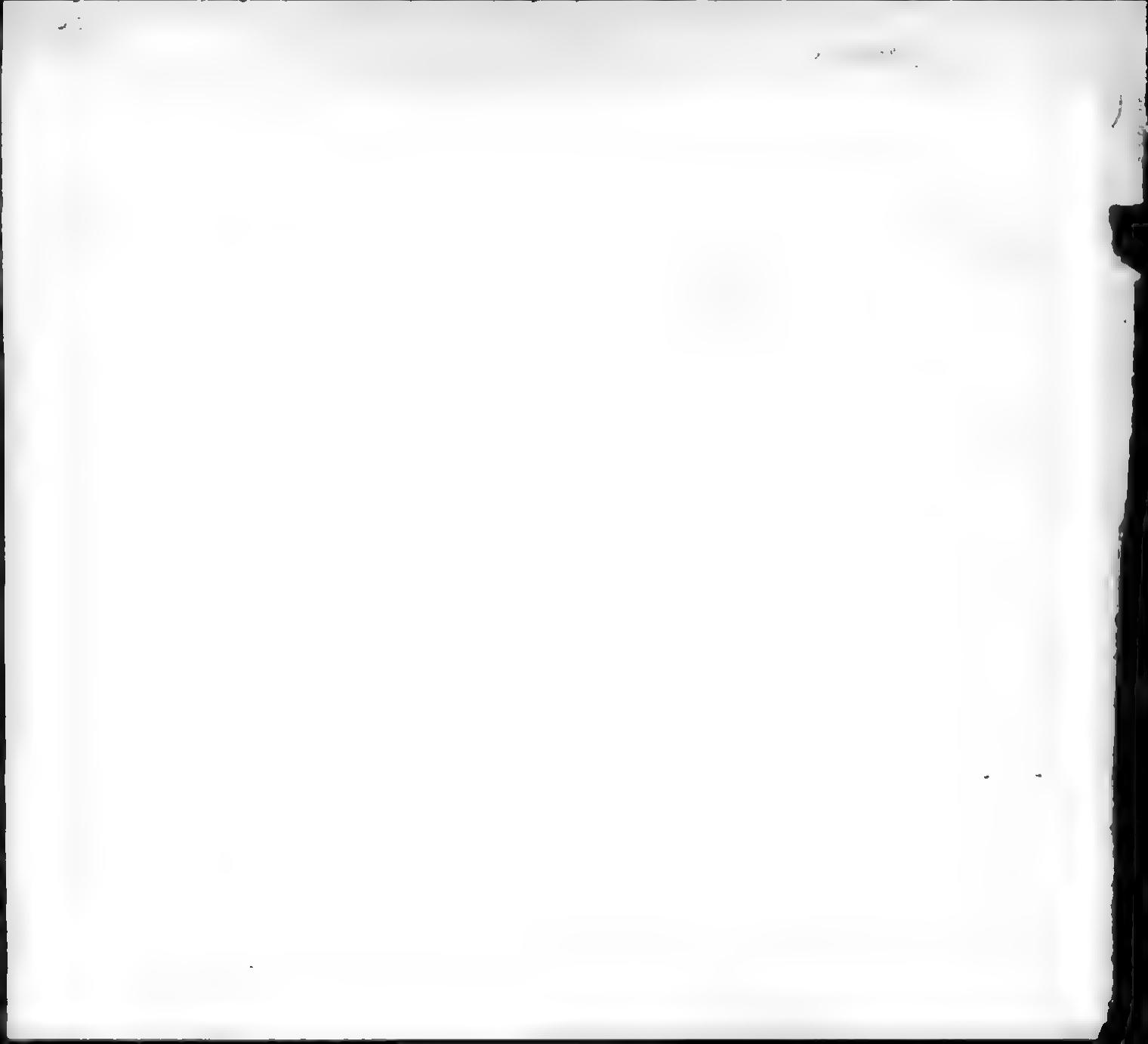
25C. FUNERAL DIRECTOR

ADDRESS

Burial 9/7/60 Lorraine Park Cemetery

Sep 7 '60 Arthur S. Straus

Mrs. J. Pickens & Sons -



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10064

CERTIFICATE OF DEATH

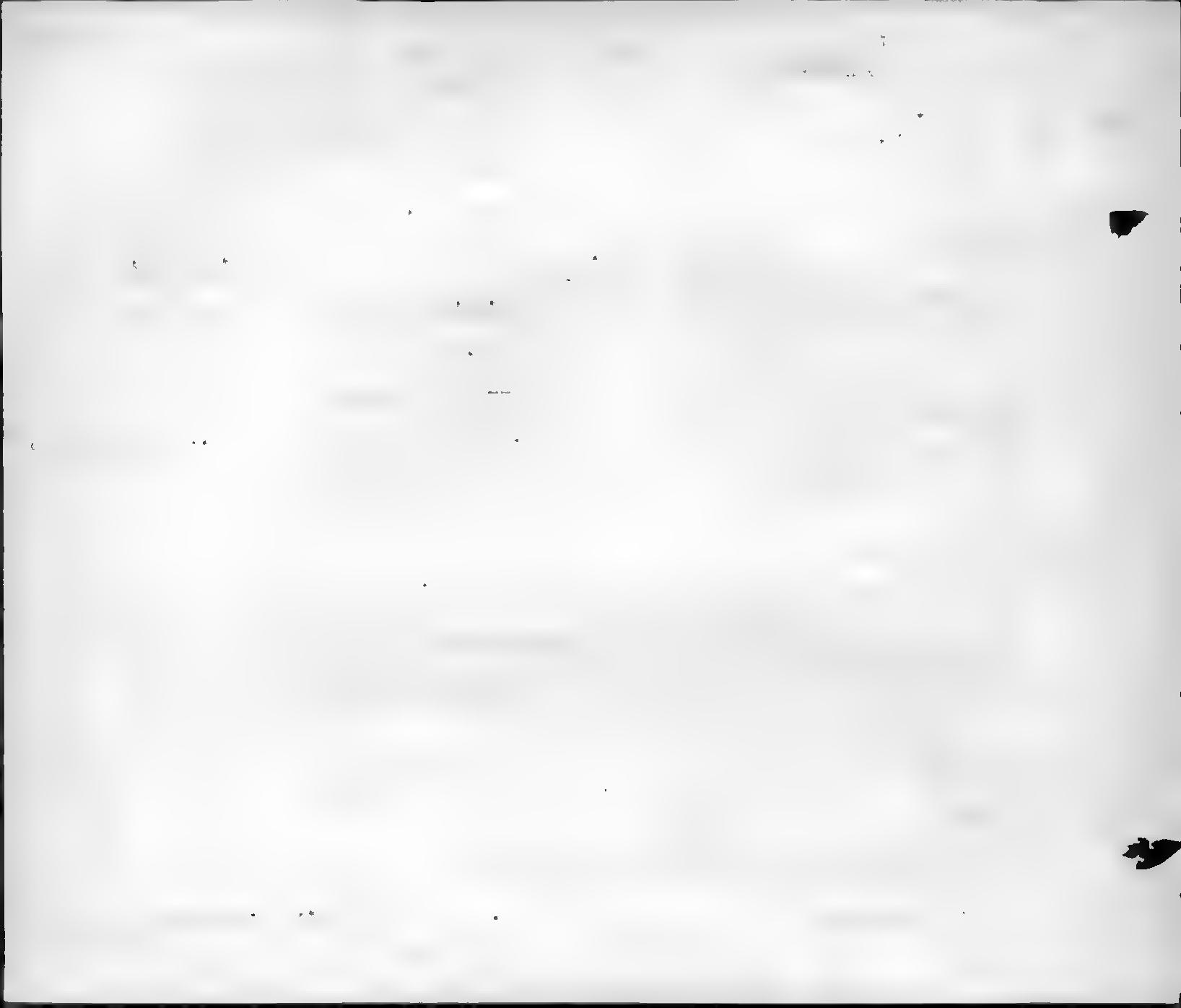
Reg. Dist. No.

10028

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS Warren Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)	First AIDA	Middle C.	Last RICKETTS	4. DATE OF DEATH	Month Sept.	Day 7	Year 1960									
5. SEX	6. COLOR OR RACE Female white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1866	9. AGE (In years lost birthday) 93 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 0	Days 0	Hours 0	Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?										
13. FATHER'S NAME David Ricketts		14. MOTHER'S MAIDEN NAME Roundtree		Address Mrs. Mary Ricketts - Warren Rd., Cockeysville, Md.												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Small Strokes DUE TO 422.0 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Degenerative Heart Disease				INTERVAL BETWEEN ONSET AND DEATH						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 8/18/60 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/18/60	20f. (City or town) 8/18/60	(County) 8/18/60	(State) 8/18/60
21. I certify that I attended the deceased from alive on 9/6/60 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE W. E. McGrath				ADDRESS (Street, city or town, state) 1303 Frederick Rd				DATE SIGNED 9/7/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/1960		22c. NAME OF CEMETERY OR CREMATORIAL Green Mount Cem.		22d. LOCATION (City, town, or county) Balto., Md.		(State) 9/7/60								
23. FUNERAL DIRECTOR'S SIGNATURE Paul J. Ricketts & Sons - Balt.		ADDRESS 17, Md.		24a. REC'D BY REGISTRAR SEP 13		24b. REGISTRAR'S SIGNATURE Paul J. Ricketts & Sons - Balt.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

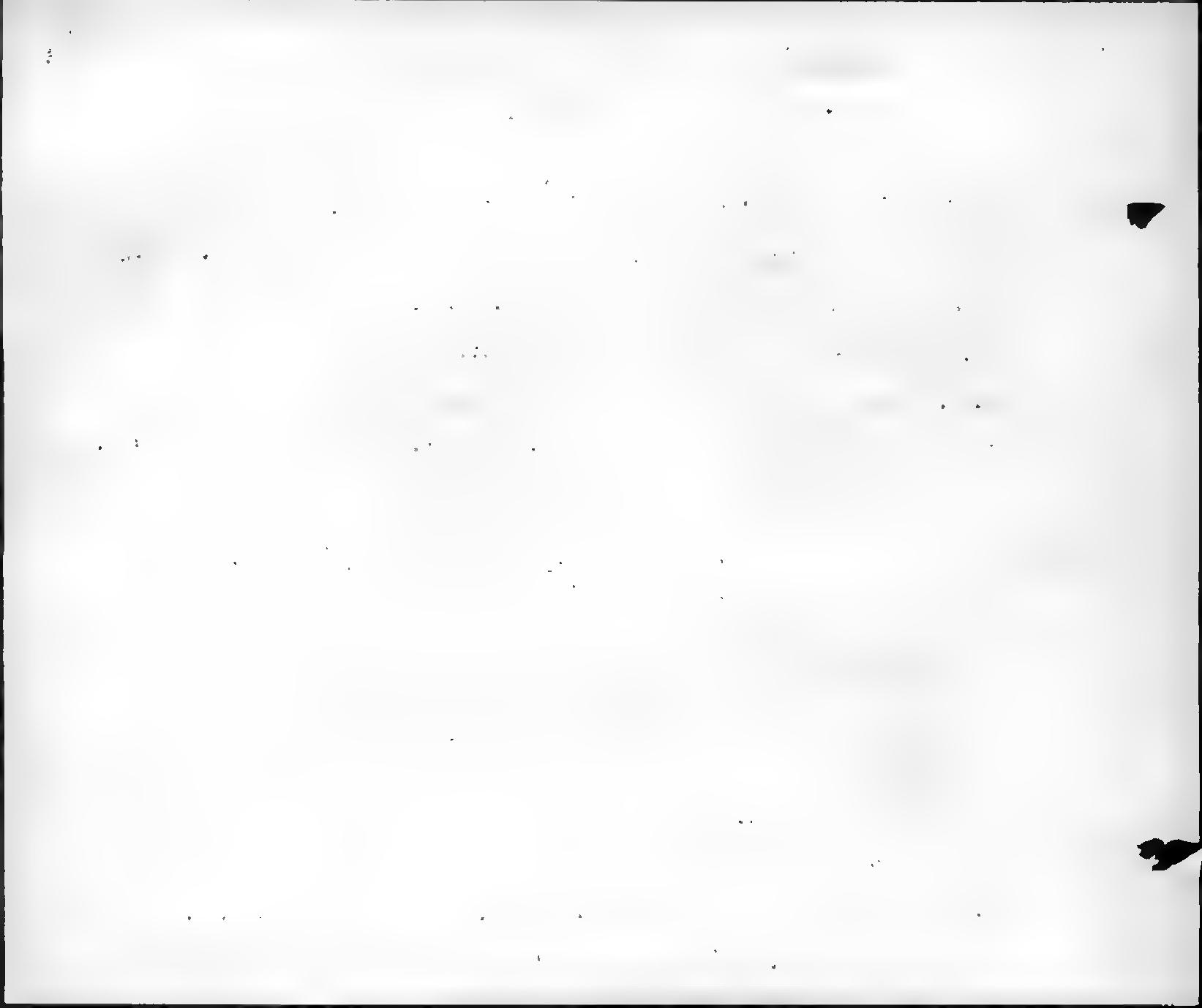
10029

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
TOWSON d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Ho. 301 Chesapeake AV				Baltimore d. STREET ADDRESS 1425 Winston Ave.						
3. NAME OF DECEASED (Type or print)		First HENRY	Middle LEWIS	Last RIECKS	4. DATE OF DEATH	Month Sept.	Day 20,	Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1881	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 79	IF UNDER 24 HRS Hours 0	IF UNDER 24 HRS Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Warehouse		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Liquor		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Wm. H. Riecks		14. MOTHER'S MAIDEN NAME Katarina Leypoldt								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT	Address Mr. Edward H. Riecks - 1425 Winston Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Virus infection & Pneumonia</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO <i>422.1</i>	(b)	<i>Congestive Heart Failure</i>						
		DUE TO	(c)	<i>Neuritis - cerebral arteriosclerosis</i>						
				<i>Aspiratio seleno sic. C.V. Descrip</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Fraility</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> , to <i>Sept 20 1960</i> , that I last saw the deceased alive on <i>Sept 20 1960</i> and that death occurred at <i>10 AM</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3033 North St Balto MD</i>								
ACTUAL SIGNATURE <i>Dr Paul Byrd</i>		DATE SIGNED <i>30 33 N North St Balto MD</i>								
PHYSICIAN'S NAME (Type) <i>Dr Paul T. Byrd</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/60	22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cem.	22d. LOCATION (City, town or county) Washington, D. C.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Larkins / John Baltz</i>		ADDRESS <i>1111 1/2 E. J. Larkins / John Baltz</i>	24a. REC'D BY REGISTRAR DATE SEP 22 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>						



14
FOR STATE
HEALTH DEPT.



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH 9948

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Lansdowne

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

September 13

Month

Day

19 60

2802 Hollins Ferry Rd.

Dey

Year

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

4-13-51

9. AGE (In years
last birthday)

9

10. UNDER 1 YEAR

Months

Days

11. UNDER 24 HRS

Hours

Min

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. K ND OF BUS NESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Melvin Ringrose

14. MOTHER'S MAIDEN NAME

Daisy Newsome

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Melvin Ringrose

same

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Drowning

929.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Drowned.

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
8:15 P.M. 9/13/6020d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)20f. (City or town)
water(County)
Baltimore(State)
Balto. Md.21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

burial 9-17-60

23. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck 5305 Harford Rd.

22c. NAME OF CEMETERY OR CREMATORIUM
New Cathedral Cem.22d. LOCATION (City, town, or county)
Baltimore, Md.

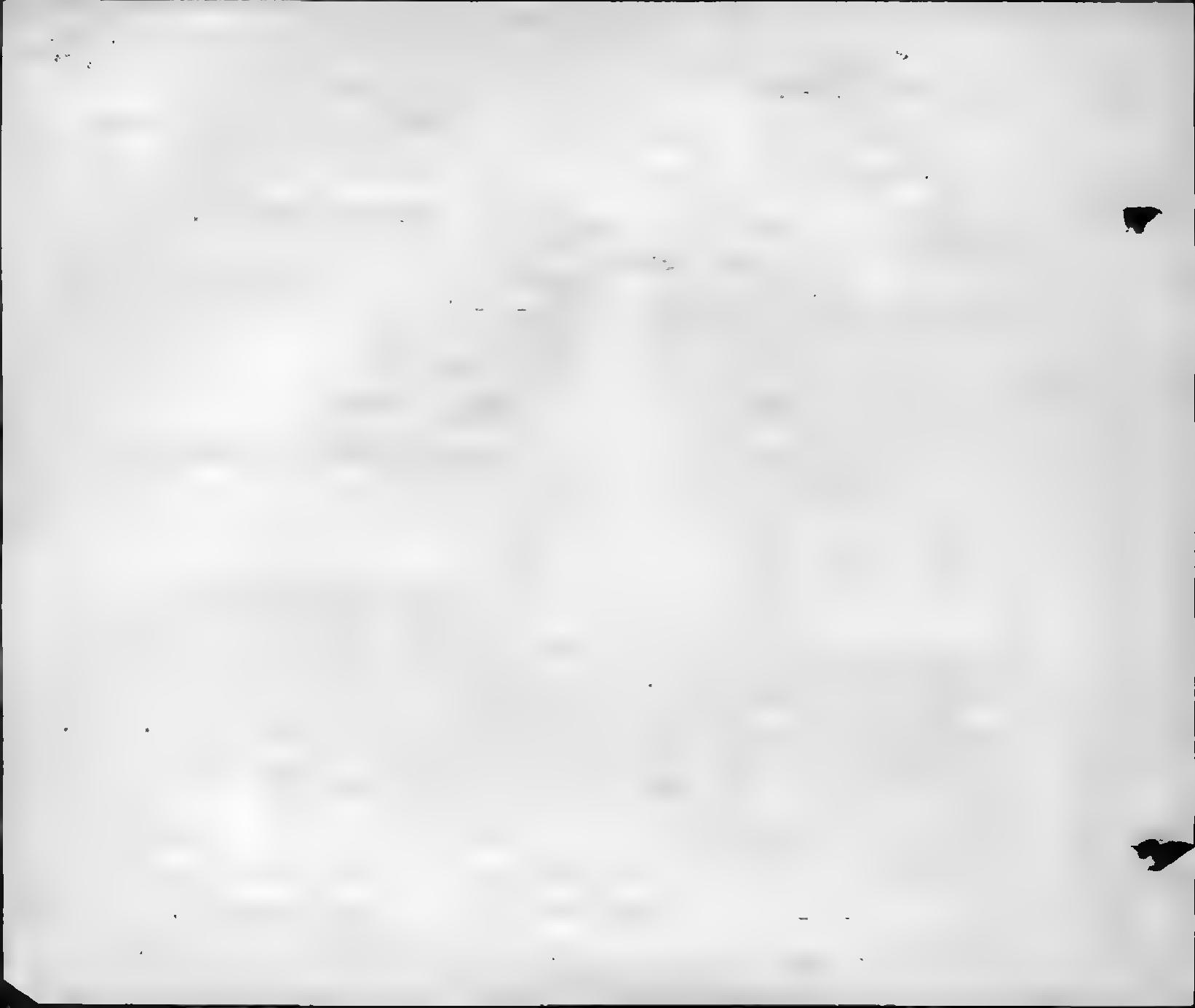
(State)

24a. REC'D BY REG. STRR SEP 16 '60
DATE

REG. STRR'S SIGNATURE

Arthur J. Knott

DATE SIGNED
September 14, 1960



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10033

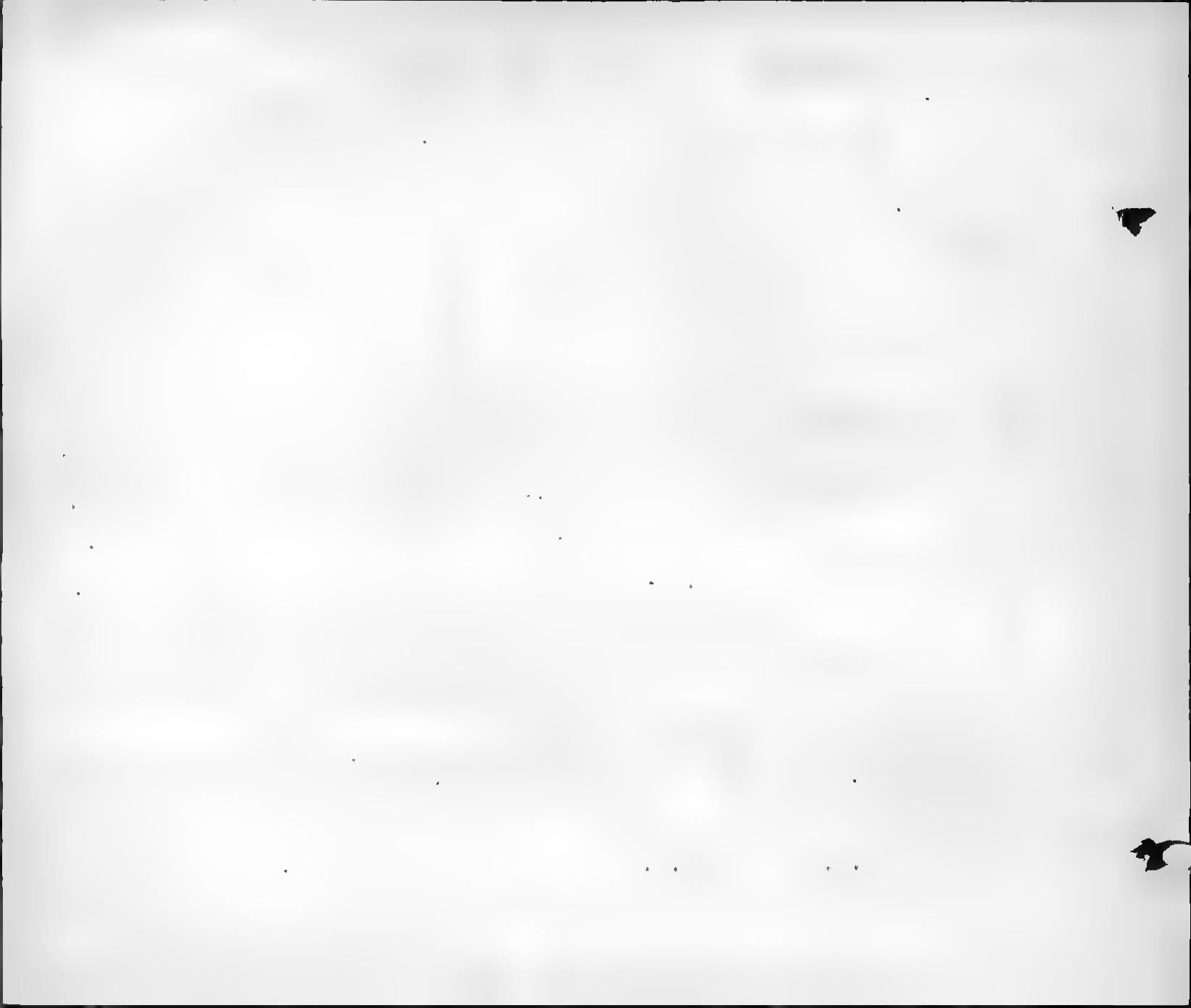
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>137 Wesley Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
3. NAME OF DECEASED (Type or print) <i>Mary A. Russ</i>		d. STREET ADDRESS <i>137 Wesley Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Female Colored</i>		6. COLOR OR RACE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH <i>Feb. 1, 1892</i>		8. AGE (In years last birthday) <i>68 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Howard Co., Md.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Howard Co., Md.</i>		11. CITIZEN OF WHAT COUNTRY <i>Mary F. Barbour</i>	
13. FATHER'S NAME <i>John Queen</i>		14. MOTHER'S MAIDEN NAME <i>Mary F. Barbour</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>528-44-5686</i>	
17. INFORMANT <i>Grace E. Brown</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>526 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Chr. Bronchitis	
		INTERVAL BETWEEN ONSET AND DEATH <i>7 days.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arthritis chronic</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 1b.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 3rd, 1960</i> , to <i>Sept. 17, 1960</i> , that I last saw the deceased alive on <i>Sept. 17, 1960</i> , and that death occurred at <i>8:30 P.M.</i> , from the causes and on the date stated above ACTUAL SIGNATURE <i>C.F. Maloney M.D.</i> ADDRESS <i>57 Winter Lane</i> DATE SIGNED <i>9/17/60</i>			
22a. PHYSICIAN'S NAME (Type) <i>C.F. Maloney, M.D.</i>		22b. DATE THEREOF <i>9/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington</i> (State) <i>VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arlington S. Phillips</i>		24a. ADDRESS <i>1808 N. Monroe St.</i>	
		24b. REGISTRAR'S SIGNATURE <i>Curious S. Phillips</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10063

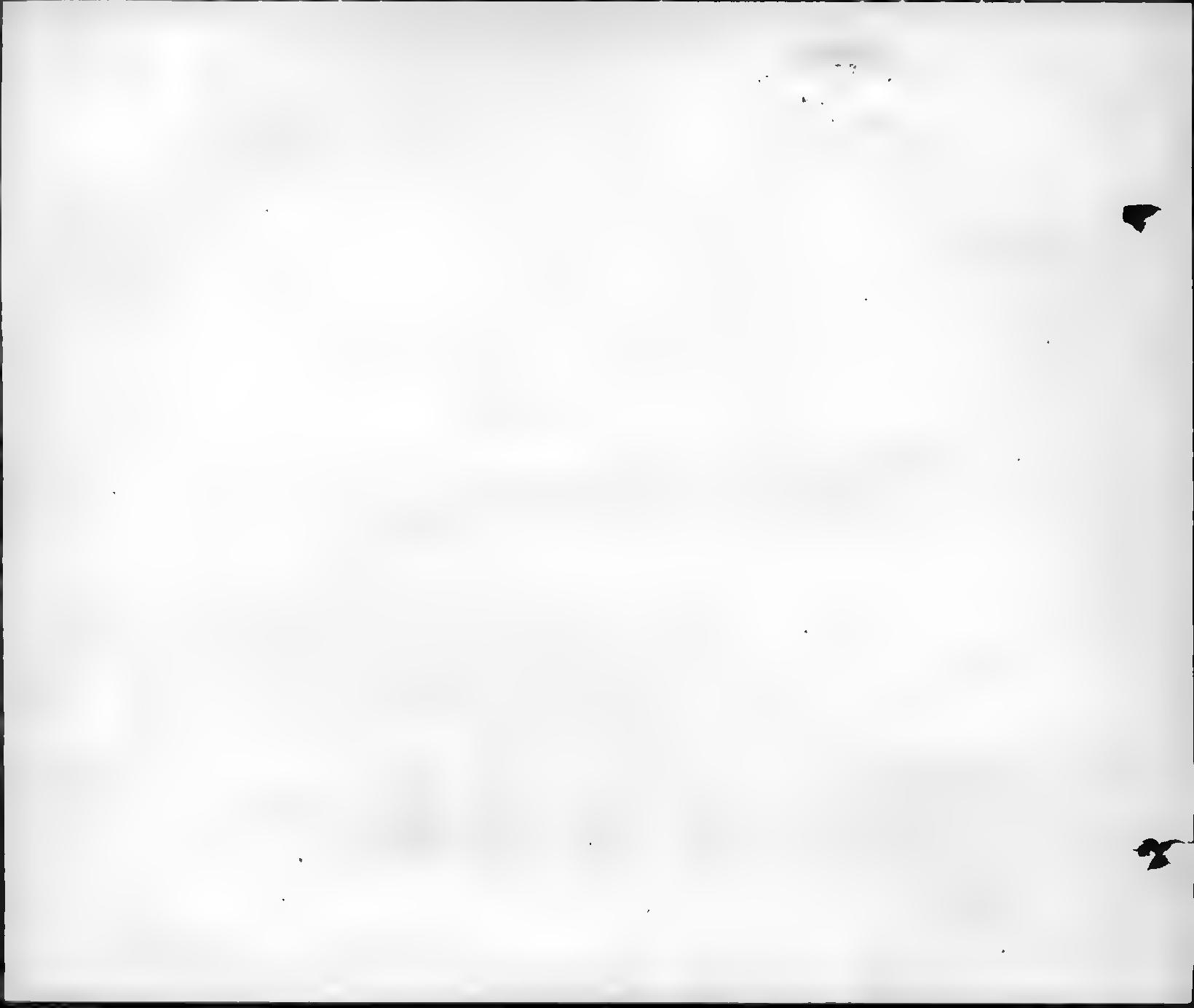
CERTIFICATE OF DEATH

10032

1
M
C
I
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	c. LENGTH OF STAY IN 1b <i>12 months</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 12</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>COLLEGE MEADOW HOME</i>	e. STREET ADDRESS <i>5219 Putney Way</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>HODMAN</i>	First <i>Grace</i>	Middle <i>Seaton</i>	Last <i>Sept 4 1960</i>
4. DATE OF DEATH <i>Sept 4 1960</i>	Month <i>Sept</i>	Day <i>4</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 3 1875</i>
9. AGE (In years last birthday) yrs. <i>85</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>New York</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>New York</i>	
13. FATHER'S NAME <i>Leander Seaton</i>	14. MOTHER'S MAIDEN NAME <i>Jessie D. Trebeck</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>142-000-0000</i>	17. INFORMANT <i>Mrs R. Steiner</i>	Address <i>5219 Putney Way</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic heart disease</i> 5 yrs <i>General Arteriosclerosis</i> 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Terminal pneumonia</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Sept 4 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State)
21. I certify that (I) (his/hospital) attended the deceased from <i>Sept 4 1960</i> to <i>Sept 4 1960</i> that (I) (we) last saw the deceased alive on <i>Sept 4 1960</i> and that death occurred at <i>9 AM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>A.S. Chalfant</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>Sept 4 1960</i>
22c. PHYSICIAN'S NAME (Type) <i>A.S. CHALFANT</i>		22d. ADDRESS <i>6210 YORK Rd. Baltimore MD</i>	
23a. BURIAL, CREMATON REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>Sept 6/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lakeview Cemetery Rockfield Springs New York</i>	23d. LOCATION (City, town, or county) (State) <i>New York</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Hall Home 4210 Elgin Road</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>SEP 13 '60</i>	25b. REGISTRAR'S SIGNATURE <i>John L. Hall</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10034

FOR STATE
HEALTH DEPT.PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

c. LENGTH OF STAY IN MD

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sparrows Point

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bethlehem Steel Co. Dispensary

3. NAME OF
DECEASED
(Type or print)

First Middle Last

WALTER RYAN (RYNAZIEWSKI)

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Age: 54 19. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS.
last birthday Months Days Hours Min.

May 2, 1906 50-55

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

John Rynazewski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank & date of service

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Yes War 11

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.0 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Arteriosclerotic Heart Disease.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a 19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
p.m. 19 While Not While factory, street, office bldg., etc.) 20f. (City or town)
at work at work

(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ANNUAL
SIGNATURE

Charles S. Petty

M.D. ASSISTANT MEDICAL EXAMINER EXAMINER'S
NAME (Type)DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/20/60

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial Sept 23, 1960 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM
Baltimore National Cemetery 22d. LOCATION (City, town, or county)
(State)

ADDRESS

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

LEO G. COOK 1701 PATTERSON PK. AVE. DATE SEP 22 '60
ARTHUR J. KRAMER

33-33

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

**FOR STATE
HEALTH DEPT.**

The logo consists of a stylized letter 'M' enclosed within a circle. Below the circle, the words 'of Holland' are written in a smaller, sans-serif font.

(DEATH) MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute file certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

(FUNERAL DIRECTOR: File pages 1 and 2 with the burial/transit permit. File page 3 with the State Board of Health.)

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										10-35
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)								
Baltimore		b. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Baltimore								
c. LENGTH OF STAY IN lb										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										
3415 Sellers Point Road										
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day	Year		
LORRAINE		DORIS	SANCHEZ	Last	September	26	1960			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR			
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/13/35	25	Months Days Hours Min.				
10a. OCCUPATION (Give kind of work done during most of working life, even if retired)										11. BIRTHPLACE (State or foreign country)
Housewife										Balto.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Joseph Sigai		Clarice Wehr								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT										Address
(Yes, no, or unknown) (If yes give war or dates of service)										None Mr. Juan C. Sanchez 3415 Sellers Pt. Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: MMED AT CAUSE (a). Massive subarachnoid hemorrhage										
330X DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO										
(c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS PER?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										YES <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJRY Month, Day Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		
Hour a.m.		19								
p.m.										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>H.W. Reelt</u>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Peter Rieckert, M.D.										M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Associate Pathologist X
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										Address (Street, city, town, or county) Baltimore
22b. DATE THEREOF 9/29/60										22d. LOCATION (City, town, or county) Baltimore
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National										
ADDRESS 2024 Orleans St										24a. REC'D BY REGISTRAR OCT 3 '60
23. FUNERAL DIRECTOR Philip Herwig & Sons										24b. REG#



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be renewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10067

CERTIFICATE OF DEATH

10036

1. PLACE OF DEATH
o COUNTY

Baltimore MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 16

18yr5mth14dys

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

3411-4

d. STREET ADDRESS

2318 E. Hoffman Street

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First Minnie

Middle

Last

4. DATE
OF
DEATH

Month September

Day 12

9 60

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

female

white

WIDOWED

DIVORCED

Jan. 19, 1876

9. AGE (In years
last birthday)

84

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

Germany

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DEFECTIVE EVER IN U. S. ARMED FORCES?
(Yes no or unknown)
unknown

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.

Due To

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Due To

Arteriosclerotic cardiovascular disease

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m. 19

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Sept. 10, 1960, to Sept. 12, 1960, that (I) (we) last
saw the deceased alive on Sept. 12, 1960, and that death occurred at p. M. from the causes and on the date stated above.

22a. SIGNATURE

Stella Wachler

M.D.

ATTENDING
PHYS.

MED
DIRECTOR

STAFF
PHYS.

9-13-60

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

Stella Wachler, M. D.

22d. ADDRESS

SPRING GROVE STATE HOSPITAL
Catoonsville 28, Maryland

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial 9/28/60 A. Peters

23d. LOCATION (City, town, or county)

(State)

Beth - Md.

24. FUNERAL DIRECTOR'S SIGNATURE

McNutt & Son Co. Corp. 28

ADDRESS

25a. REC'D. BY REGISTRAR
SEP 29 '60
DATE

25b. REGISTRAR'S SIGNATURE
Charles S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician and completely filled in by the funeral director.

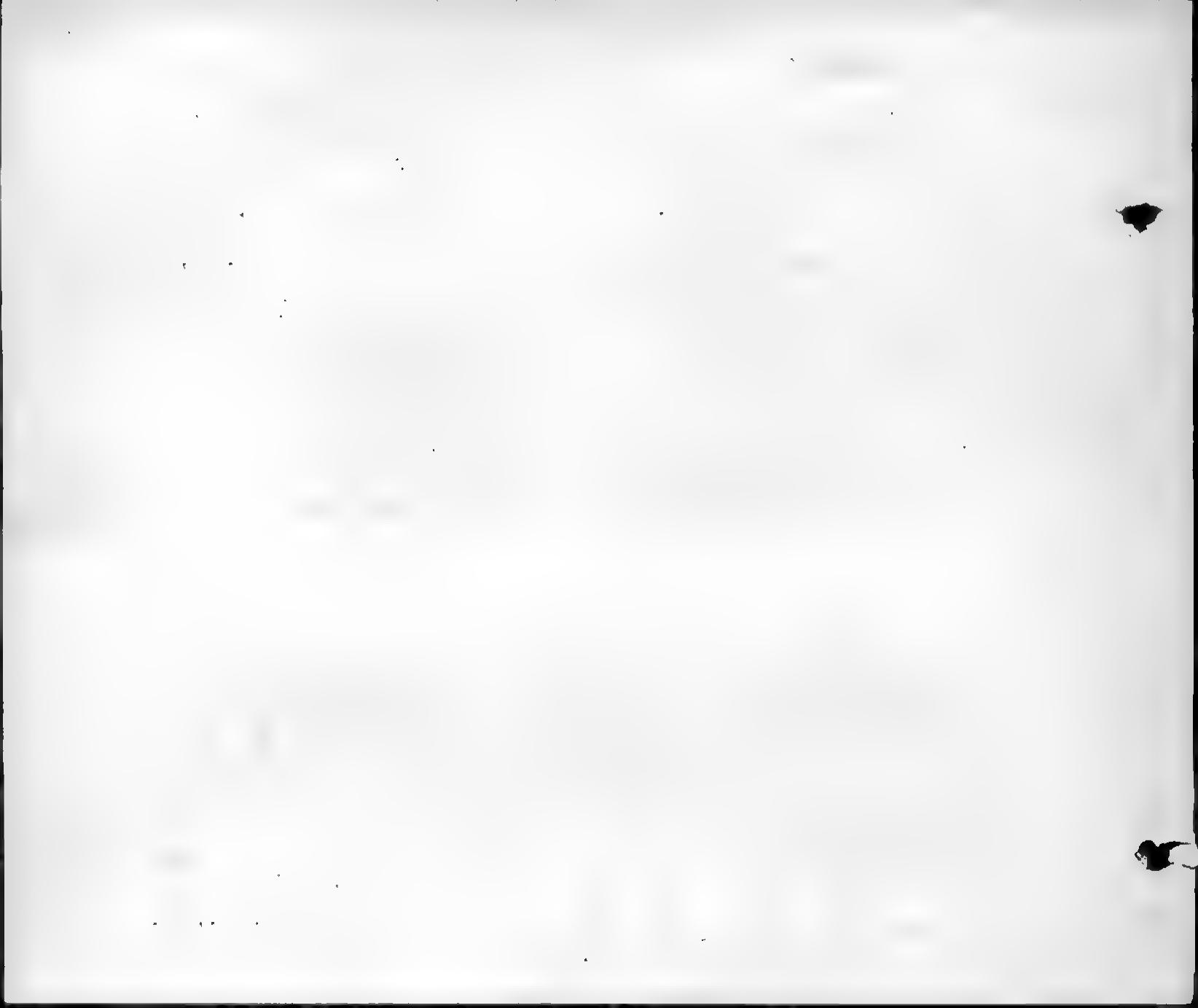
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10037

CERTIFICATE OF DEATH

10038														
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Essex 21					c. LENGTH OF STAY IN lb Essex 21					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 701 Christian Ave.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 701 Christian Ave.					d. STREET ADDRESS 701 Christian Ave.					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Lillian Scharmer		First Anna		Middle Lillian		Last Scharmer		4. DATE OF DEATH Sept. 18, 1960		Month Day Year Sept. 18, 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/1883		9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Home					11. BIRTHPLACE (State or foreign country) Hungary				
13. FATHER'S NAME Joseph Nahler					14. MOTHER'S MAIDEN NAME Anna Szabadsag					12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Scharmer		Address Same								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 199.1 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) Circulatory failure Bronchopneumonia, bilateral Cancer of the lower abdomen 12 hours. 6 days 6 to 12 months										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition due to cancer.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)												
20c. TIME OF INJURY Month, Day, Year Hour o m 20d. INJURY OCCURRED p. m. 19 White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)						
21. I certify that (I) (this hospital) attended the deceased from 3/26/60 to 9/18/60 , that (I) () last saw the deceased alive on 9/18/60 , and that death occurred at 5 P.M. from the causes and on the date stated above														
22a. SIGNATURE Eugene C. Baumann										22b. DATE SIGNED 9/19/60				
22c. PHYSICIAN'S NAME (Type) Eugene C. Baumann		22d. ADDRESS 413 Eastern Ave., Baltimore 21, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/60		23c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		23d. LOCATION (City, town, or county) Baltimore Co., Md.								
24. FUNERAL DIRECTOR'S SIGNATURE James Brzozinski										25a. REC'D BY REGISTRAR Arthur S. Thomas				
ADDRESS 1007 Eastern Ave.										25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				
DATE SEP 20 '60														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

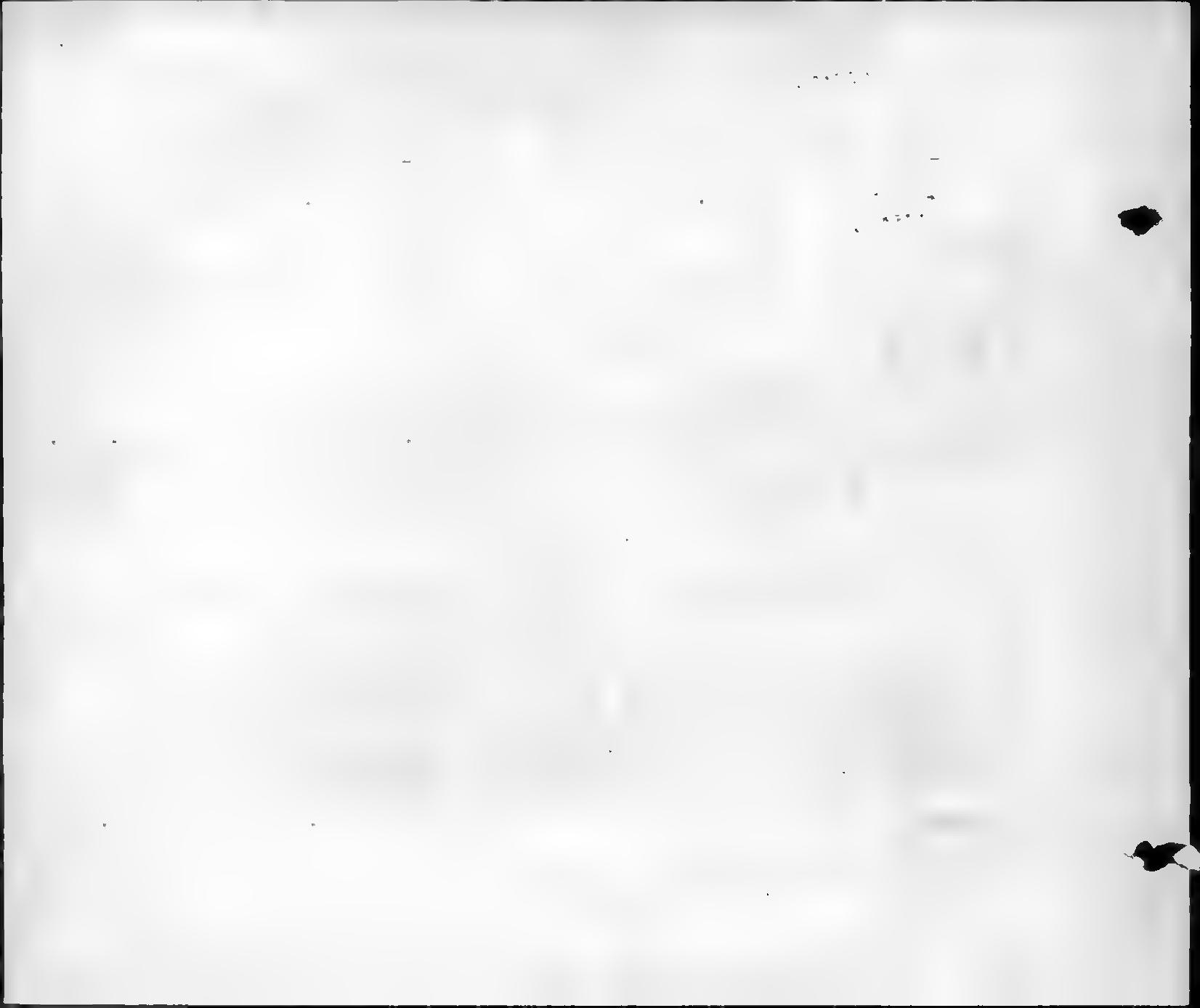
10069

CERTIFICATE OF DEATH

10038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Randallstown		c LENGTH OF STAY IN lb 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3306 Offutt Rd.		d STREET ADDRESS 3306 Offutt Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Henry	Last Schmidt	4. DATE OF DEATH Month 9	Month 9	Day 14	Year 1960
5. SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-1880	9. AGE (in years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Gardener		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Schmidt				14. MOTHER'S MAIDEN NAME Elizabeth Kennell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (See, no. or unknown) NO		16. SOCIAL SECURITY NO 218-32-6253		17. INFORMANT Wife -- Mrs. Mary Schmidt, Offutt Rd. Rand.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism INTERVAL BETWEEN ONSET AND DEATH 1 week							
410A Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Rheumatic heart disease 35 years							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-10- , 19 59 , to 9-14-60 , 19 60 , that I last saw the deceased alive on 9-13 , 19 60 , and that death occurred at 8:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 8204 Liberty Rd. Baltimore, Md. DATE SIGNED							
ACTUAL SIGNATURE Edwin L. Pierpont							
PHYSICIAN'S NAME (Type) Edwin L. Pierpont, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60		22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas Church, Garrison, Md.		22d. LOCATION (City, town, or county) (State) Garrison, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Rd.		24a. REG'D. BY REGISTRAR DATE SEP 16 60		24b. REGISTRAR'S SIGNATURE Loring S. Knapp	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

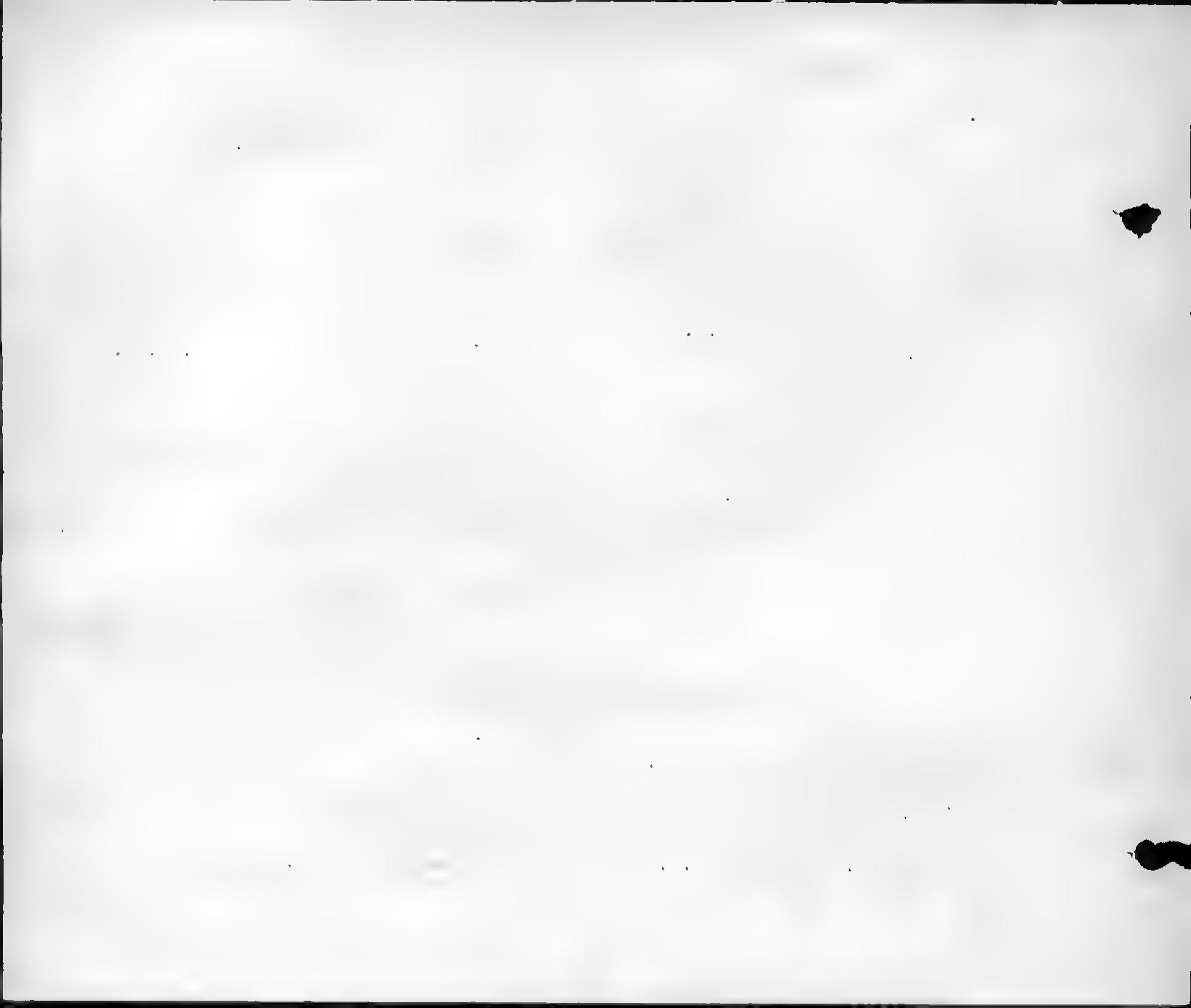
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10040

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Texas		b. COUNTY Bexar		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN lb 80 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Antonio		d. STREET ADDRESS 237 Escalon Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (Signed) LOUISE LOUISE		First	Middle IRENE IRENE	Last NEILL SCHULTZ)	4. DATE OF DEATH September 27 1960	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> January 6, 1909	9. AGE (in years last birthday) 51	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government Air Civil Service Base		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12 CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Oscar T. Schultz		14. MOTHER'S MAIDEN NAME Irene Throop		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170X CARCINOMA OF THE LEFT BREAST WITH (TOTAL MASTECTOMY 1950) WITH GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO CACHEXIA (c)		INTERVAL BETWEEN ONSET AND DEATH 10 YEARS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 9 1960, to September 27 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 19 1960 and that death occurred at A. M. from the causes and on the date stated above.		22b. DATE SIGNED 9/27/60						
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION				
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/25/60		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery		23d. LOCATION (City, town or county) Baltimore (State) Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Henry Sanders & Sons, Inc. North Ave. & Broadway		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE SEP 29 '60		25b. REGISTRAR'S SIGNATURE Albert S. Kraus		



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 16 <i>15 months</i>		b. COUNTY <i>Ocean City</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5743 Edmonson Ave. Kingsway Home Nursing Home</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>							
3. NAME OF DECEASED (Type or print)		First <i>FANNIE</i>	Middle <i></i>	Last <i>SENEY</i>	4. DATE OF DEATH <i>Sept. 10 1960</i>	Month <i>Sept.</i>	Day <i>10</i>	Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>July 23-1872</i>	9. AGE (In years last birthday) <i>88 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS Days <i></i>	Hours <i></i>	Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hauswifey</i>		11. BIRTHPLACE (State or foreign country) <i>Ocean City Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Stephen Kimble</i>		14. MOTHER'S MAIDEN NAME <i>Mary Robinson</i>		Address <i>George E. Society 3634 Shirley Ave. Baltimore Md.</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Barney Thompson</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>400.1</i>		DUE TO (b) <i>Arteriosclerotic C. V. Disease</i>		(c) <i>Senility</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Senility</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> 1955, to <i>Sept. 11</i> , 1960 that (I) (we) last saw the deceased alive on <i>Sept. 11</i> 1960 and that death occurred at <i>11 AM</i> from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <i>D. C. MacLaughlin</i>		ATTENDING PHYS <i>D. C. MacLaughlin</i>		MED D. RECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <i>D. C. MacLaughlin, M.D.</i>		22d. ADDRESS <i>4508 Edmondson Village Baltimore 29, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 13-60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Church Hill</i>		23d. LOCATION (City, town, or county) <i>Church Hill</i>		(State) <i>Maryland</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>James Horatio Fletcher</i>		ADDRESS <i>1101 E. Pratt St. Baltimore 2, Md.</i>		25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE <i>James Horatio Fletcher</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10072

CERTIFICATE OF DEATH

10042

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cockeysville		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cockeysville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		203 Padonia Road		e. STREET ADDRESS		203 Padonia Road		e. IS RESIDENCE A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First MOLLIE	Middle ELIZABETH	Last Safford	4. DATE OF DEATH		Month September	Day 13	Year 1960	
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min		
Female	White	WIDOWED <input checked="" type="checkbox"/>	Dec. 13, 1880							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housewife		Own Home		North Carolina		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Clayton Fry		Jane Campbell								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		None		None		Family Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 1 hour										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last										
(b) Myocarditis - Decompensating 5 yrs										
DUE TO (c) Hypertension & arterosclerosis 5 yrs										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour a. m. ✓ p. m.		19	While at work	Not while at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from 1-1-68 to 9-13-60, that (I) (we) last saw the deceased alive on 9-13-60, and that death occurred 24 M. from the causes and on the date stated above.										
22a. SIGNATURE <i>Jones G. Safford</i>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 9-15-60				
22c. PHYSICIAN'S NAME (Type) <i>Jones G. Safford</i>					22d. ADDRESS Reisterstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)		
Burial		Sept. 17, 1960		Poplar Grove Cemetery		Cockeysville, Carroll				
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland					ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>John Burns</i>		
							DATE SEP 16 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

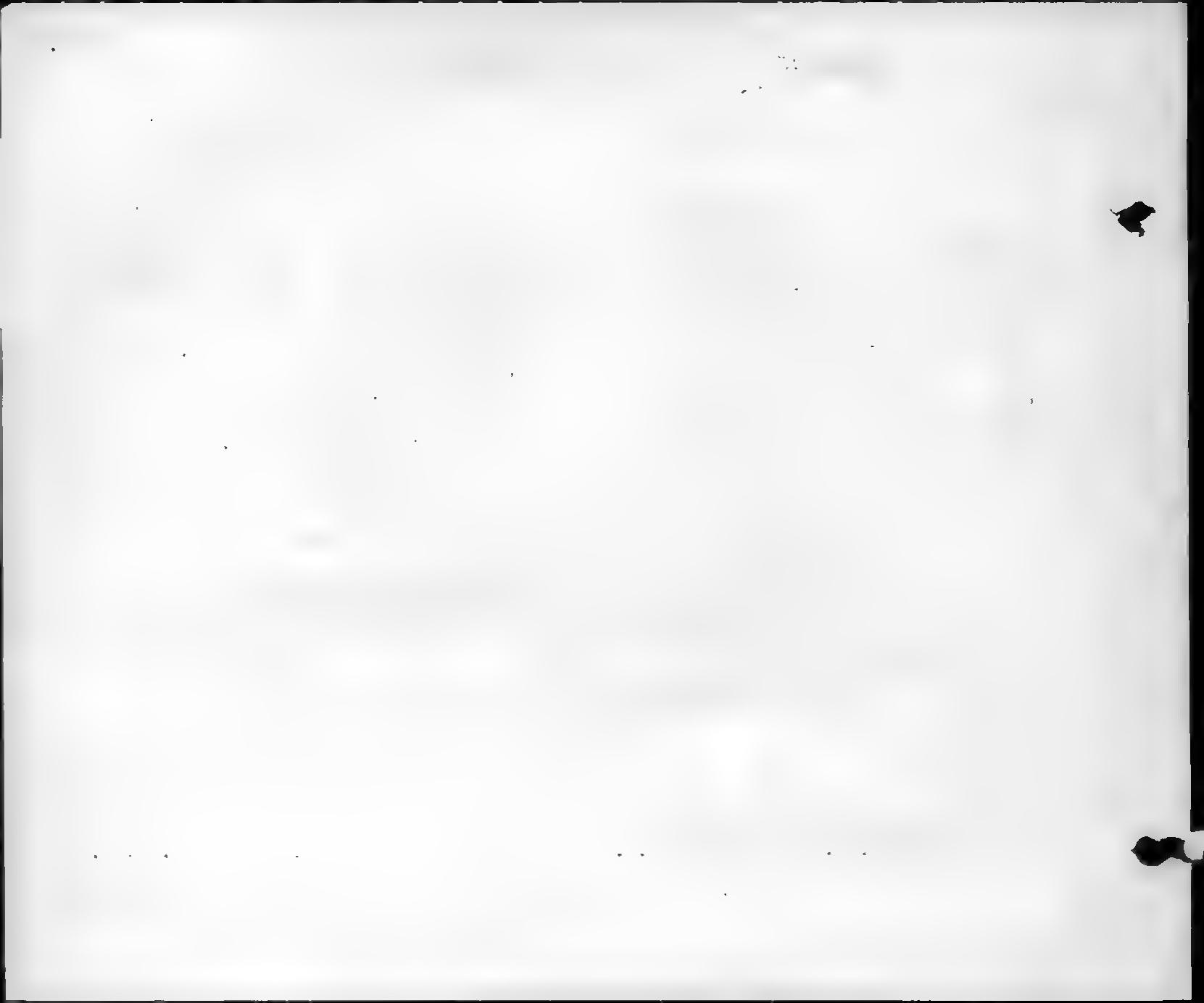
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10043

1 PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 6 yrs		d. STATE Md., b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. STREET ADDRESS	
Summit Nursing Home Blithewood Ave		Gatonsville		619 Southmont Rd	
3 NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Sept. 14/60
5 SEX Female		6. COLOR OR RACE W.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1875	9. AGE (In years last birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hampstead, Md. U. S. A.	
Companion				12. CITIZEN OF WHAT COUNTRY? Hampstead, Md. U. S. A.	
13. FATHER'S NAME George Lee		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
				16. SOCIAL SECURITY NO.	
17. INFORMANT Ruth L. Smarinson, 619 Southmont Rd.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 260 X DUE TO		Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) Atherosclerotic C.V. Disease		?	
		(c) Diabetes mellitus		1 month	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fibrility				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept. 13, 1960, to Sept. 14, 1960, that (I) (we) last saw the deceased alive on Sept. 13, 1960, and that death occurred at 12 A.M., from the causes and on the date stated above				22b. DATE SIGNATURE Sept. 15/60	
22c. PHYSICIAN'S NAME (Type) Dr. C. MacLoughlin, Jr.		MD ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 410 Edmondson Ave, Baltimore, Md.	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF Sept. 17/60		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F. L. 410 Edmondson Ave		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 16 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Knott	



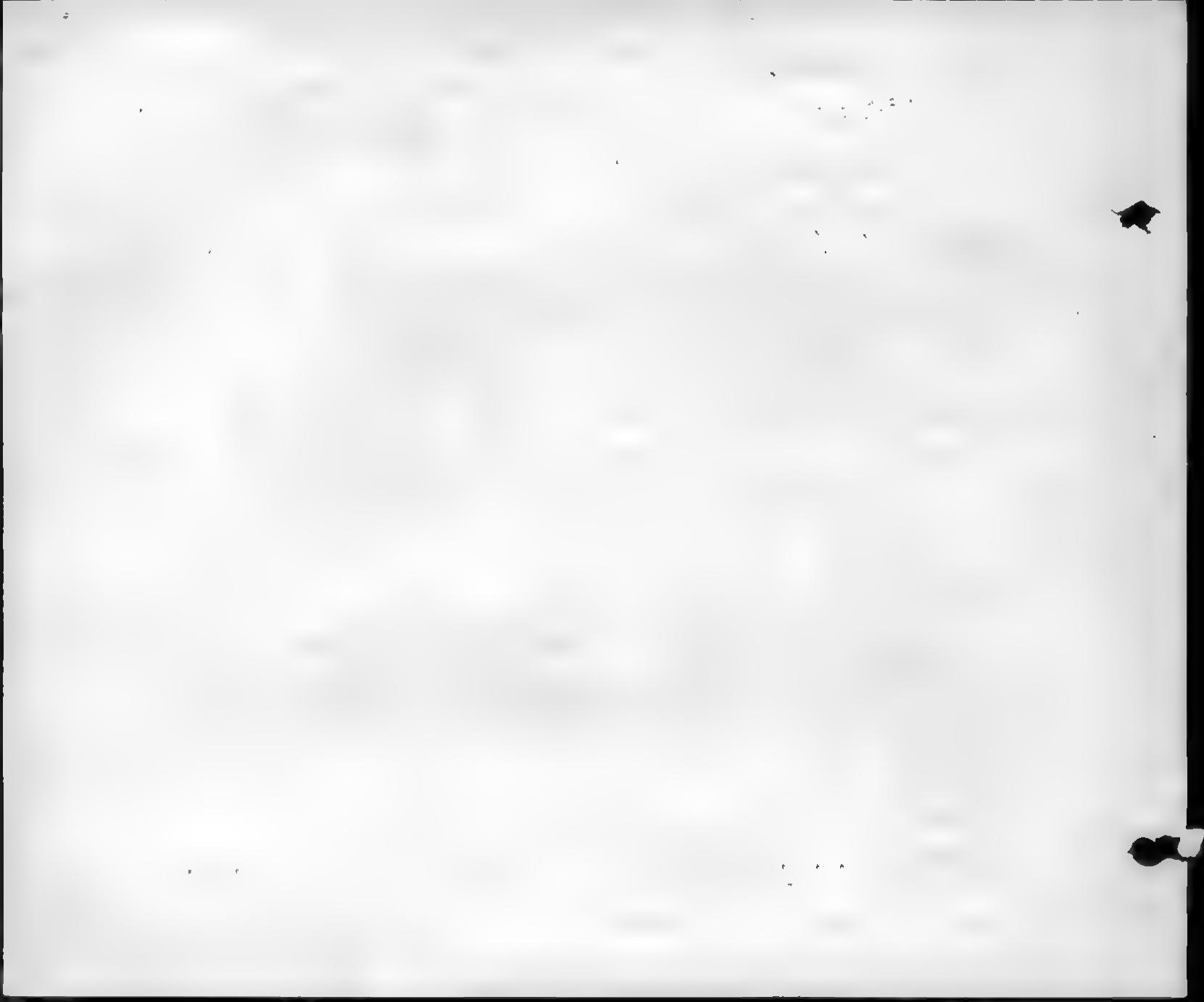
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute it on a separate sheet, writing the word "Pending", in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10044**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 mo. 13	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sspring Grove State Hosp/		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
3. NAME OF DECEASED (Type or print) Washington First W. and 11 Middle Wadacell Wellington-Smith		d. STREET ADDRESS Cockeysville Road	
4. DATE OF DEATH Month Sept. Day 9, 1960 Year 19		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-1871	
9. AGE (In years last birthday) 89 yrs.		10. UNDER 14 YEARS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Smith		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT Record Of Hospital		Address Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which goes rise to immediate cause (a), stating the underlying cause last. 184.9			
(b) Generalized arteriosclerosis			
DUE TO (c) Fracture right femur (accidental) by fall on floor			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on floor	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Catonsville (County) Balto. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. M. Kieffer M.D.</i>		DATE SIGNED Sept. 10, 1960	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept. 12, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Immanuel Church Cem.		22d. LOCATION (City, town, or county) Glencoe, Balto Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Son, Towson, Md.		24a. REC'D BY REGISTRAR DATE Sept. 13 '60	
		24b. REGISTRAR'S SIGNATURE Clifford S. Head	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

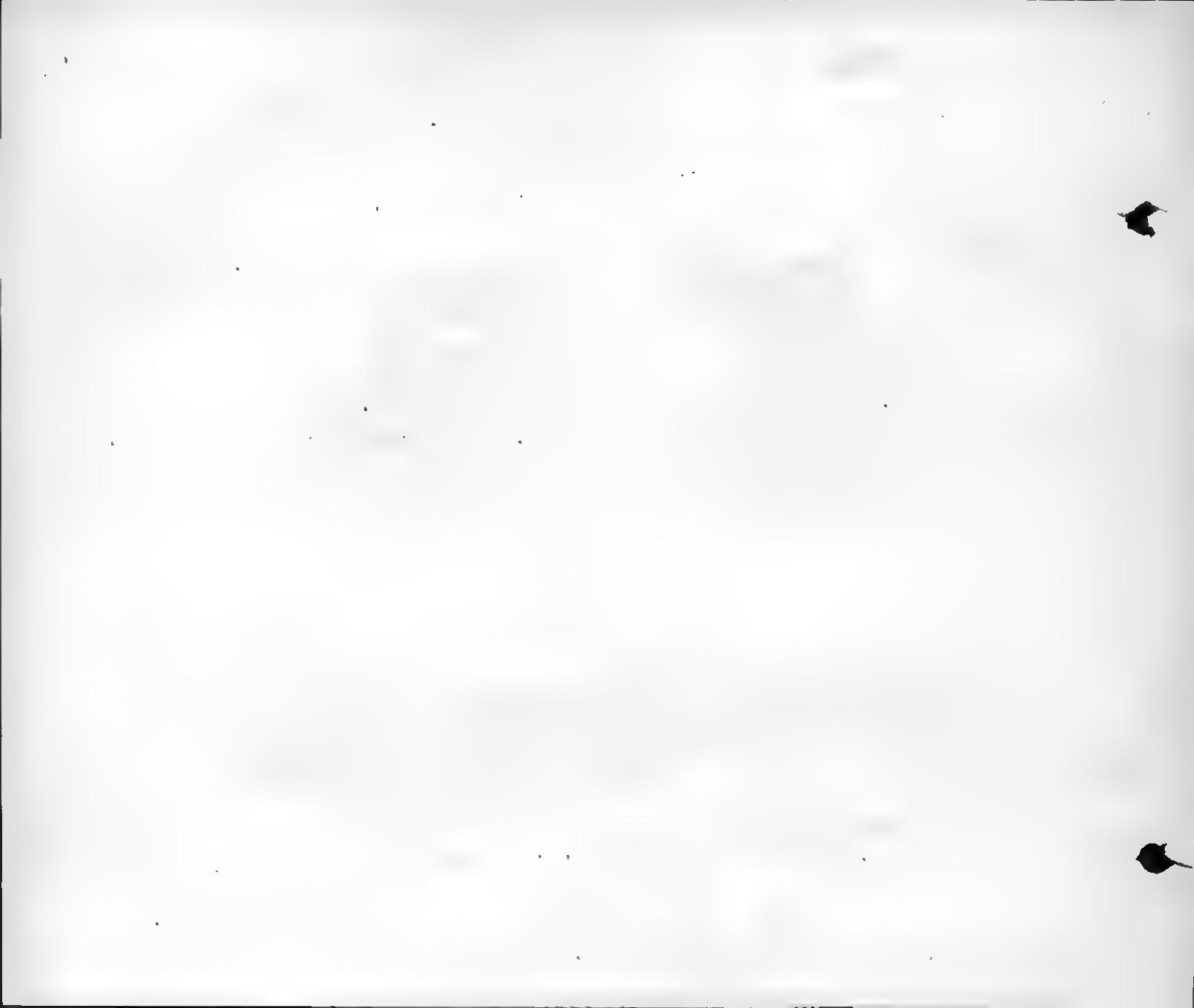
10045

9949

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		d. STREET ADDRESS 612 Gun Rd.	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 612 Gun Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Viola Sonnenberg				July 30, 1884	Sept. 19, 1960	19	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 30, 1884		9 AGE (in years last birthday) 76 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Elmer E. Read		14. MOTHER'S MAIDEN NAME Sarah L. Shannon		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eleanora Clayton 612 Gun Rd.			
no		none					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO c)		<i>Hypertension, cerebral hemorrhage. Age 3 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>Cerebral arteriosclerosis.</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above.							
22a. SIGNATURE <i>A. Bradley Daugherty, M.D.</i>		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>Sept. 22, 1960</i>
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugherty, M.D.		22d. ADDRESS <i>612 Gun Rd., Baltimore, Md.</i>					
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 9/22/60		23c NAME OF CEMETERY OR CREMATORIAL Baltimore		23d LOCATION (City, town or county) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Edward H. Hubbard 4107 Wilkens Ave.		ADDRESS		25a REC'D BY REGISTRAR DATE SEP 22 '60		25b REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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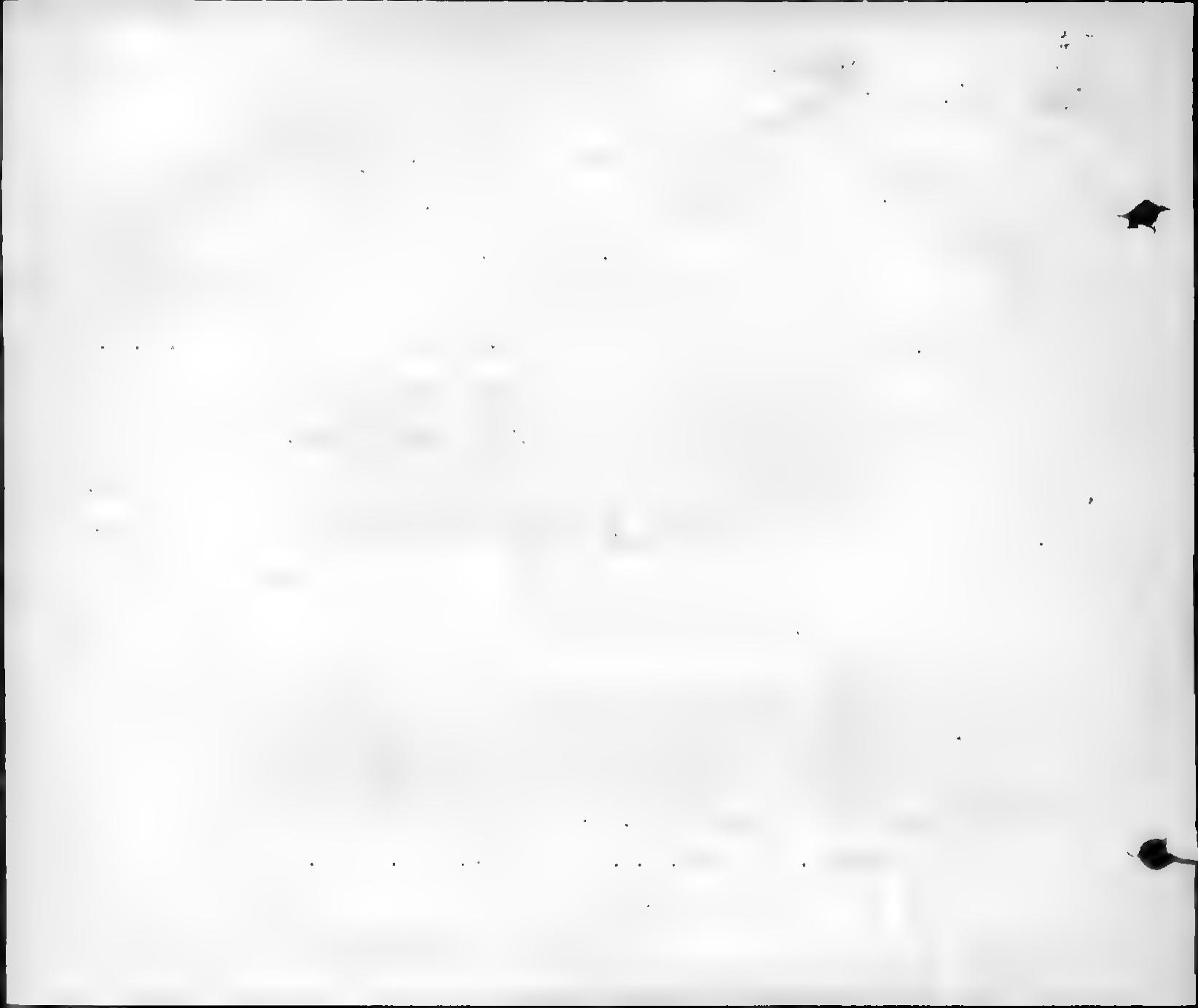
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10046

1. PLACE OF DEATH COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (25)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 4020 Eighth Street		f. DATE OF DEATH September 22 1960		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle E.	Last SOPER	Month	Day	Year	
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. DATE OF BIRTH June 11, 1920	8. AGE (in years last birthday) 40 yrs	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Hours 0	11. IF UNDER 24 HRS Min 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Paper Box Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George H. Soper				14. MOTHER'S MAIDEN NAME Mabel Swift			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW II 213-10-9310		17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 453. / PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLISMS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. X AND ANASARCA DUE TO MARKED CARDIOMEGLY WITH CARDIAC DECOMPENSATION DUE TO (c) BUERGER'S DISEASE DUE TO SURGICAL AMPUTATION							
INTERVAL BETWEEN ONSET AND DEATH 3 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Operation Amputation both legs 11/4/57							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sept. 22 1960					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 6 1960 to Sept. 22 1960, that (we) last saw the deceased alive on Sept. 22 1960, and that death occurred at A.M., from the causes and on the date stated above.							
22a. SIGNATURE Fredrick S. Donaldson		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 9/22/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully Funeral Home		ADDRESS 237 Patapsco Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 '60		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



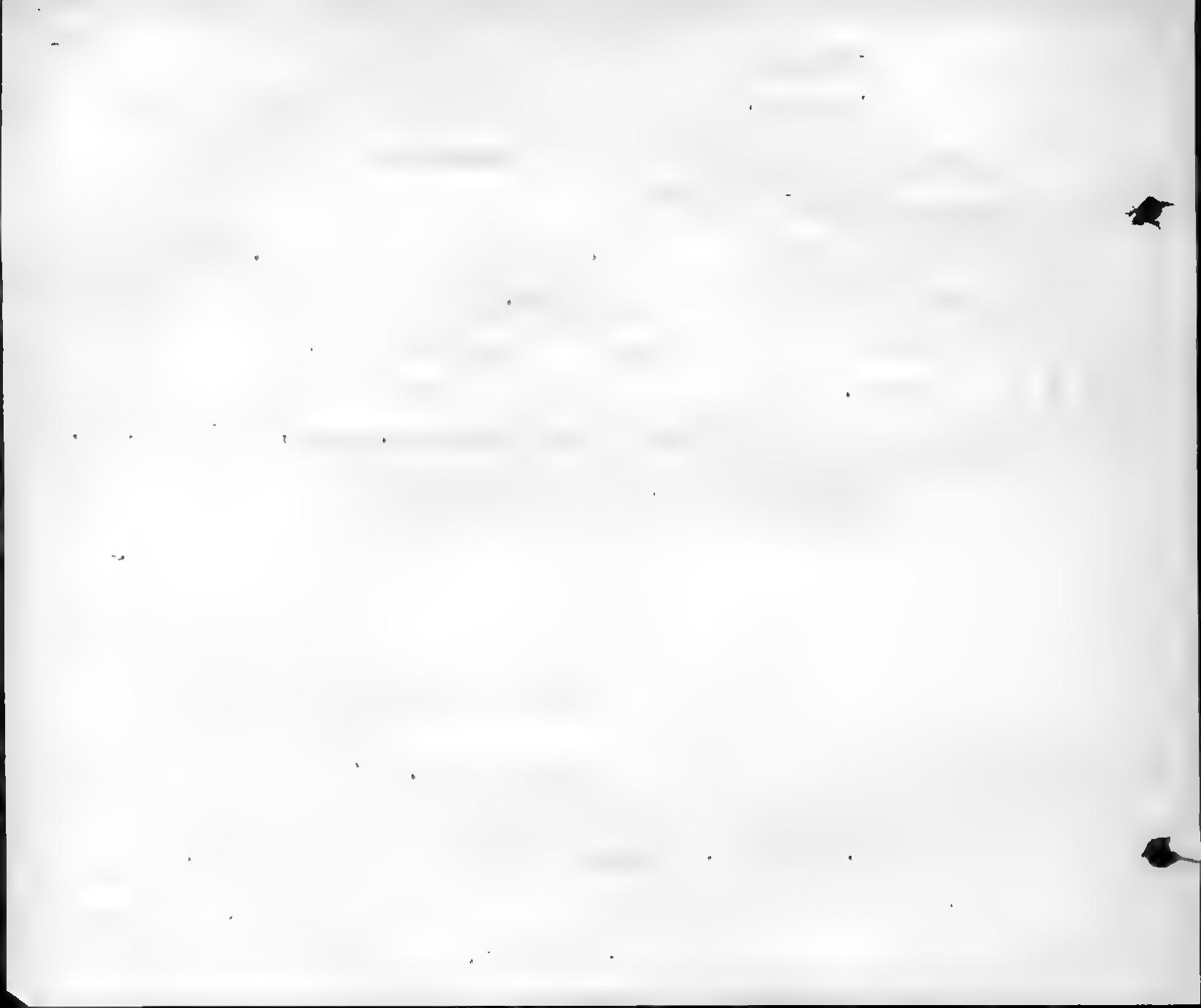
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

100676 10047

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL (If not a hospital, give street address) House in the Pines Nursing and Convalescent Home			d. STREET ADDRESS Arbutus Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marie.	Middle L.	Last Spoerer	4. DATE OF DEATH	Month Sept. 15th	Day 19	Year 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21st 1876	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Days 5	12. Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			
13. FATHER'S NAME Louis C. Smith			14. MOTHER'S MAIDEN NAME Elisabeth Schmidt			12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Raymond P. Delano, Nottingham, Pa.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>								<i>1 day</i>	
Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last { (b) <i>Deceased prior to marriage</i> DUE TO (c) <i>Deceased prior to marriage</i> DUE TO								<i>159 -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Maryland	(State)
21. I certify that (I) (this hospital) attended the deceased from 9-14-1960 to 9-15-1960 , that (I) (we) lost sow the deceased alive on 9-14-1960 , and that death occurred 11.45 A.M. from the causes and on the date stated above.								22b. DATE SIGNED 9-16-60	
22a. SIGNATURE <i>Wilmer K. Gallager</i>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 9-16-60	
22c. PHYSICIAN'S NAME (Type) Dr. Wilmer K. Gallager		22d. ADDRESS 6209 Frederick Avenue.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17th 1960		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ellis Lamoreau</i>		ADDRESS 1003 W. Balto. St.		25a. REC'D BY REGISTRAR DATE SEP 19 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



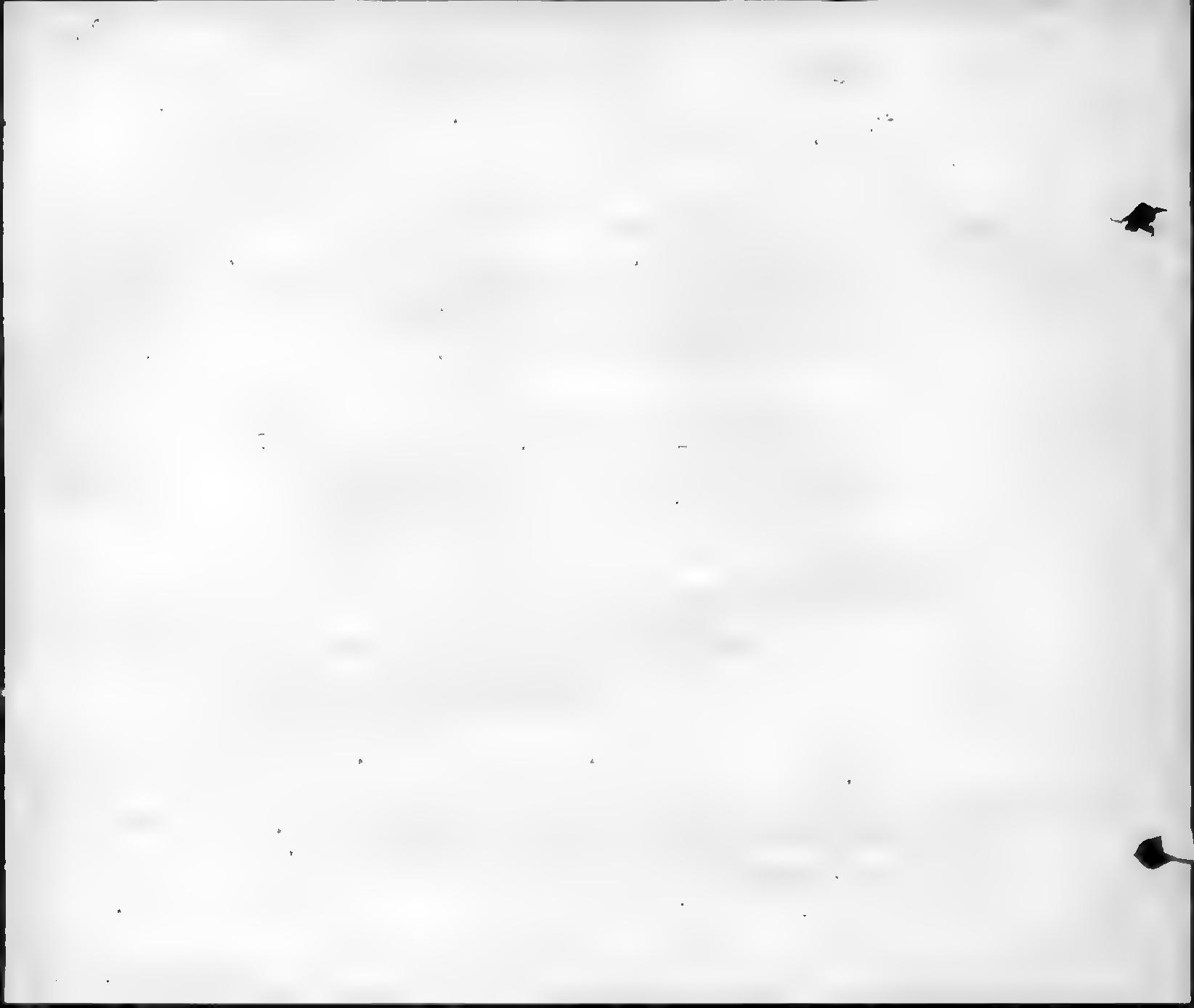
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b 8 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Maiden Choice Lane		d. STREET ADDRESS 102 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary L. Stickel		First	Middle	Last	4. DATE OF DEATH Month Sept. Day 18, Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1886	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader		10b. KIND OF BUSINESS OR INDUSTRY Business Form		10c. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Daum			14. MOTHER'S MAIDEN NAME Elizabeth Sellman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO. 216-10-6226		17. INFORMANT Mrs. Charles E. Weisbar 102 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19 52, to Sept. 19 60, that I last saw the deceased alive on Sept. 18, 19 60, and that death occurred at 12:57 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>J. Howard Strong</i> 9/20/60					
PHYSICIAN'S NAME (Type) Lee J. Geyer		M.D. 1 Mallow Hill Ave., Baltimore 29, Md.			
22a. BURIAL/CREMATON REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-1960		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore	
22d. LOCATION (City, town, or county) Baltimore		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Howard Strong</i>		ADDRESS 3287 W. North Ave.		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
				24b. REGISTRAR'S SIGNATURE <i>Celia S. Kraus</i>	



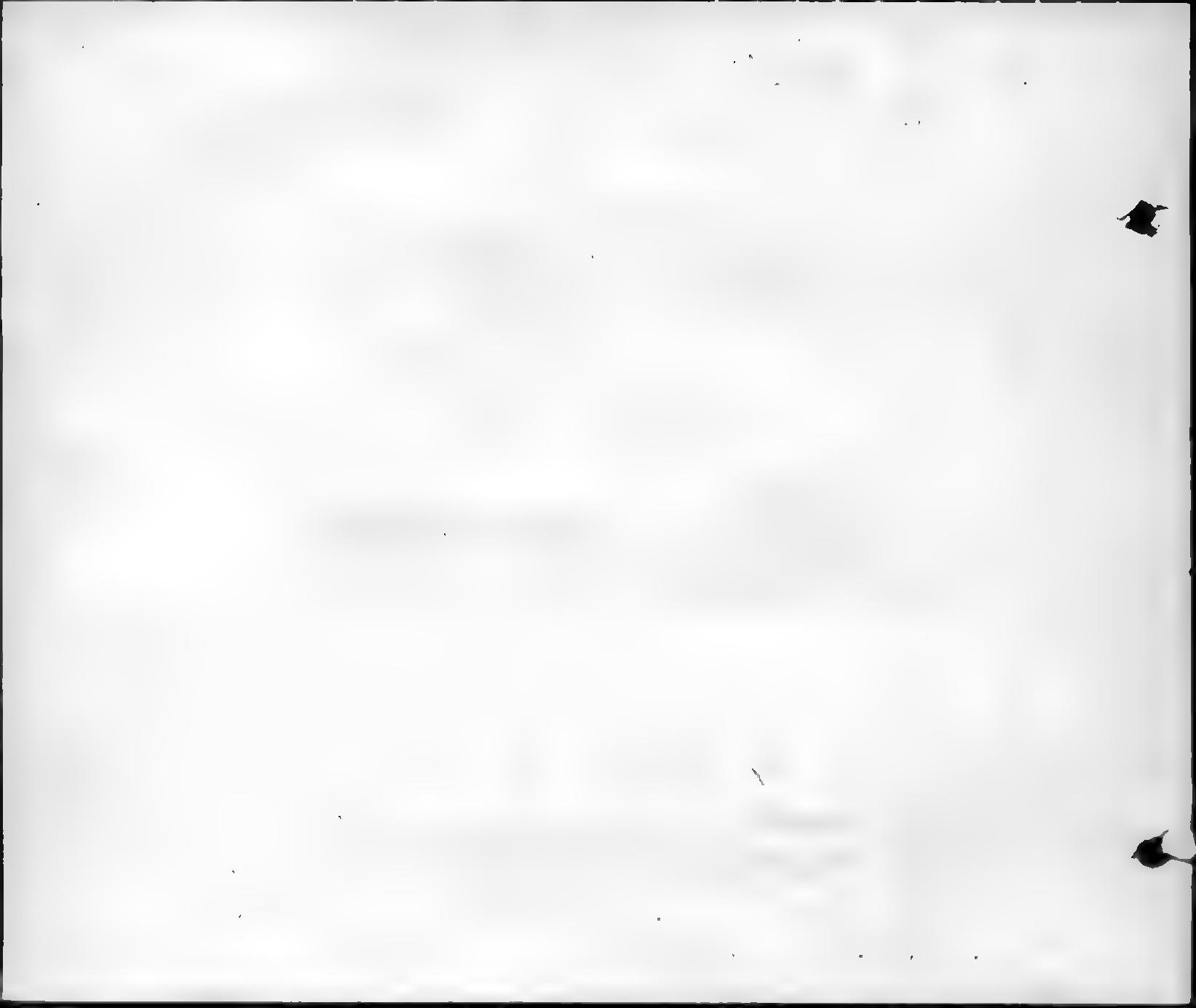
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10050

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		10078 BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND Pri. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 6 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MASONIC HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOHN	Middle FORNEY	Last STONER	4. DATE OF DEATH	Month SEPT	Day 20	Year 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min	
MALE		WHITE		11-23-1886	73 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
PRINTER				MARYLAND		U.S.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		Address		
JOHN C. STONER				SUSAN E. FORNEY,		Frank L. Smith Jr - Cockeysville, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter on one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		
		578-050-5575		Frank L. Smith Jr - Cockeysville, Md.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		
						Arteriosclerotic Cardiovascular Disease 6 yrs.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		
						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
						20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-27 1957, to 9-20 1960, that (I) (we) last saw the deceased alive on 9-19 1960, and that death occurred at 240P, from the causes and on the date stated above.		22a. SIGNATURE <i>Walter T. Kees</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>9/20/60</i>		
22c. PHYSICIAN'S NAME (Type)		WALTER T. KEEPS		22d. ADDRESS		COCKEYSVILLE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-22-60		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Md		
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 12k7 St. Paul Street		ADDRESS		25a. REG'D BY REGISTRAR SEP 22 1960		25b. REGISTRAR'S SIGNATURE Charles S. Krause		



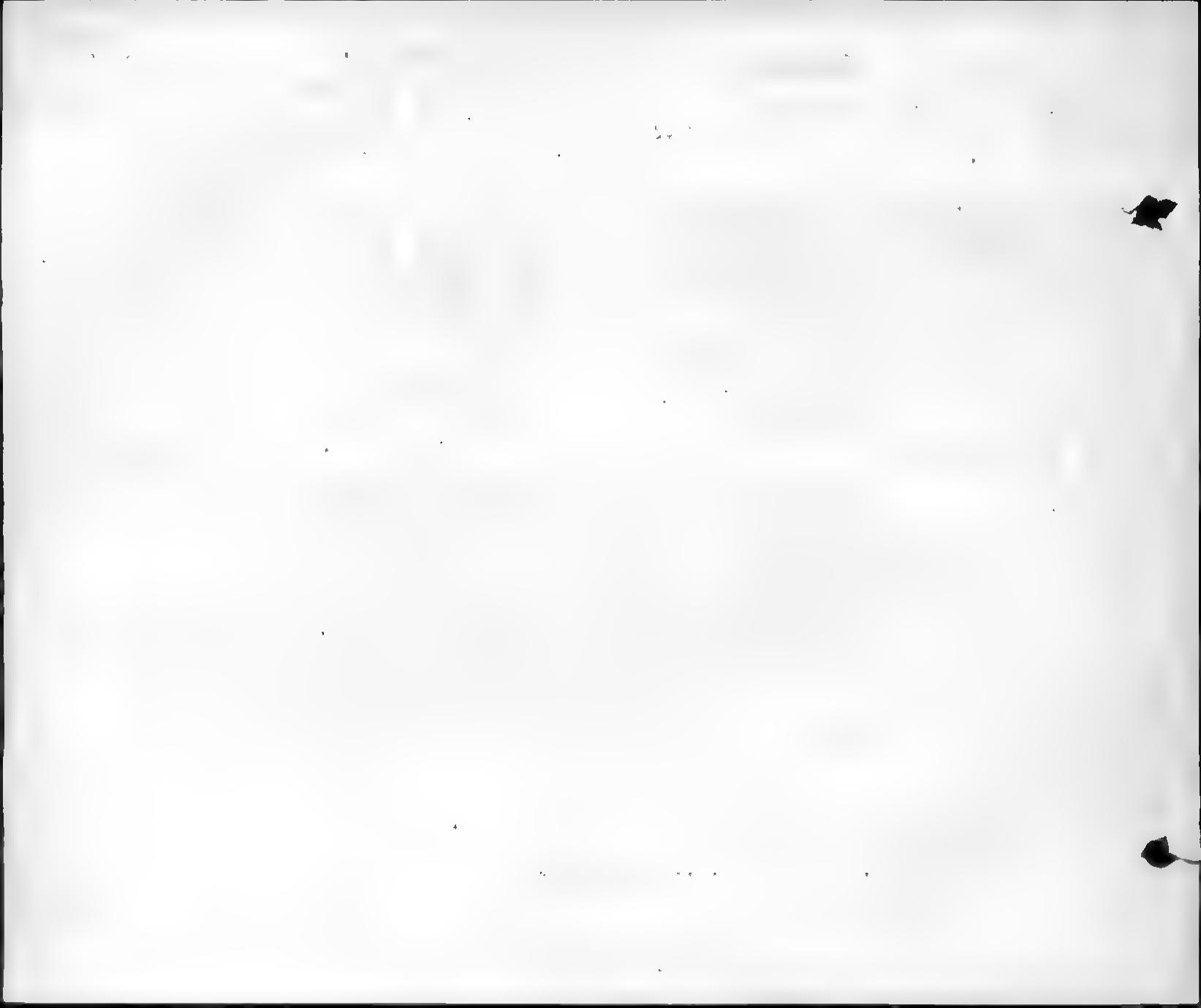
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10051
32

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saint Pleasant	
3. NAME OF DECEASED (Type or print) KATE		4. DATE OF DEATH Sept. 26 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 20 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
10c. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) 75 yrs	
13. FATHER'S NAME WILLIAM TUDGE		14. MOTHER'S MAIDEN NAME LENA SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pott's disease & spinal compression, and pulmonary infection.			
INTERVAL BETWEEN ONSET AND DEATH 4 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Left nephritis, etc., etc. Thrombocytopenia, fine l & lt renal veins			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) falling from bed, fine l & lt renal veins	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1-1960 to 9-26-1960 that I last saw the deceased alive on 9-26-1960 , and that death occurred at 1 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland			
DATE SIGNED 9-26-1960			
ACTUAL SIGNATURE William Newcomer			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-60	
22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		22d. LOCATION (City, town, or county) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jameson Bros.			
ADDRESS 1661 - Woodlawn Rd. SE W 45th. DC		24a. REC'D BY REGISTRAR Arthur J. Smith	
		24b. REGISTRAR'S SIGNATURE Arthur J. Smith	



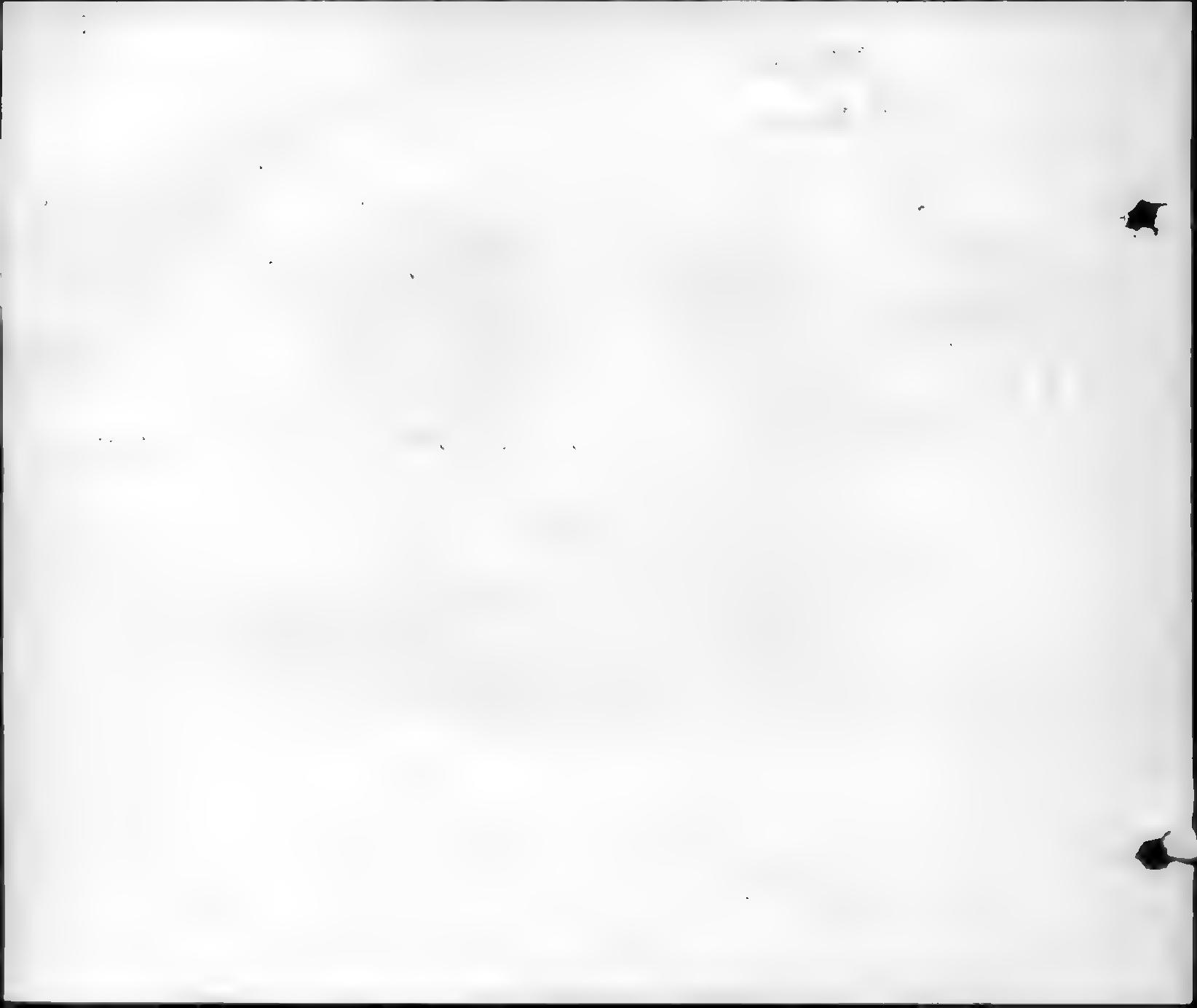
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10052

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodmoor</i>		c. LENGTH OF STAY IN 1b <i>7 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodmoor</i>		d. STREET ADDRESS <i>13439 Mayta Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3439 Mayta Road</i>				d. STREET ADDRESS <i>13439 Mayta Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Annette W. Stoller</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept. 8/60</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4, 1876</i>	9. AGE (In years last birthday) <i>84 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. U.S. & AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>A.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home Person.</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Joseph Woods</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Martin</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>		17. INFORMANT <i>Mrs. Elmer E. Shellkoff</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Hypertensive arteriosclerotic Cardio Vascular w.</i>								
INTERVAL BETWEEN ONSET AND DEATH								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 7 1960, and that death occurred at 6 AM, from the causes and on the date stated above.		21b. DATE SIGNED <i>Sept 8 1960</i>						
22a. SIGNATURE <i>Albert Scagnetti</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>Sept 8 1960</i>				
22c. PHYSICIAN'S NAME (Type) <i>ALBERT SCAGNETTI</i>		22d. ADDRESS <i>1729 W Lombard St</i>						
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>Sept. 8/60</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Clayton Creek Cem.</i>		23d. LOCATION (City, town or county) (State) <i>New Berlin, Penna.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Withey, F. L. 4101 Edmondson Ave</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>SEP 13 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10053

10081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>None</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6118 Falls Road</i>		e. STREET ADDRESS <i>6118 Falls Road</i>	
3. NAME OF DECEASED (Type or print) <i>Robert A. Elliott</i>		4. DATE OF DEATH <i>July 28, 1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 11, 1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery Store</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>James Folk Elliott</i>		14. MOTHER'S MAIDEN NAME <i>Lough</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-1269A</i>	17. INFORMANT <i>Robert Elliott, 6118 Falls Road</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>321 Donkirk Rd</i>	
ACTUAL SIGNATURE <i>R. Victor Richards</i>		DATE SIGNED <i>Charles Victor Richards</i>	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>July 1, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethel Cemetery, Maryland</i>	22d. LOCATION (City, town, or county) <i>Stevensville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgess Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Office of the Clerk</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Klaus</i>
ADDRESS <i>3631 Falls Road</i>		DATE <i>SEP 3 0 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
 15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

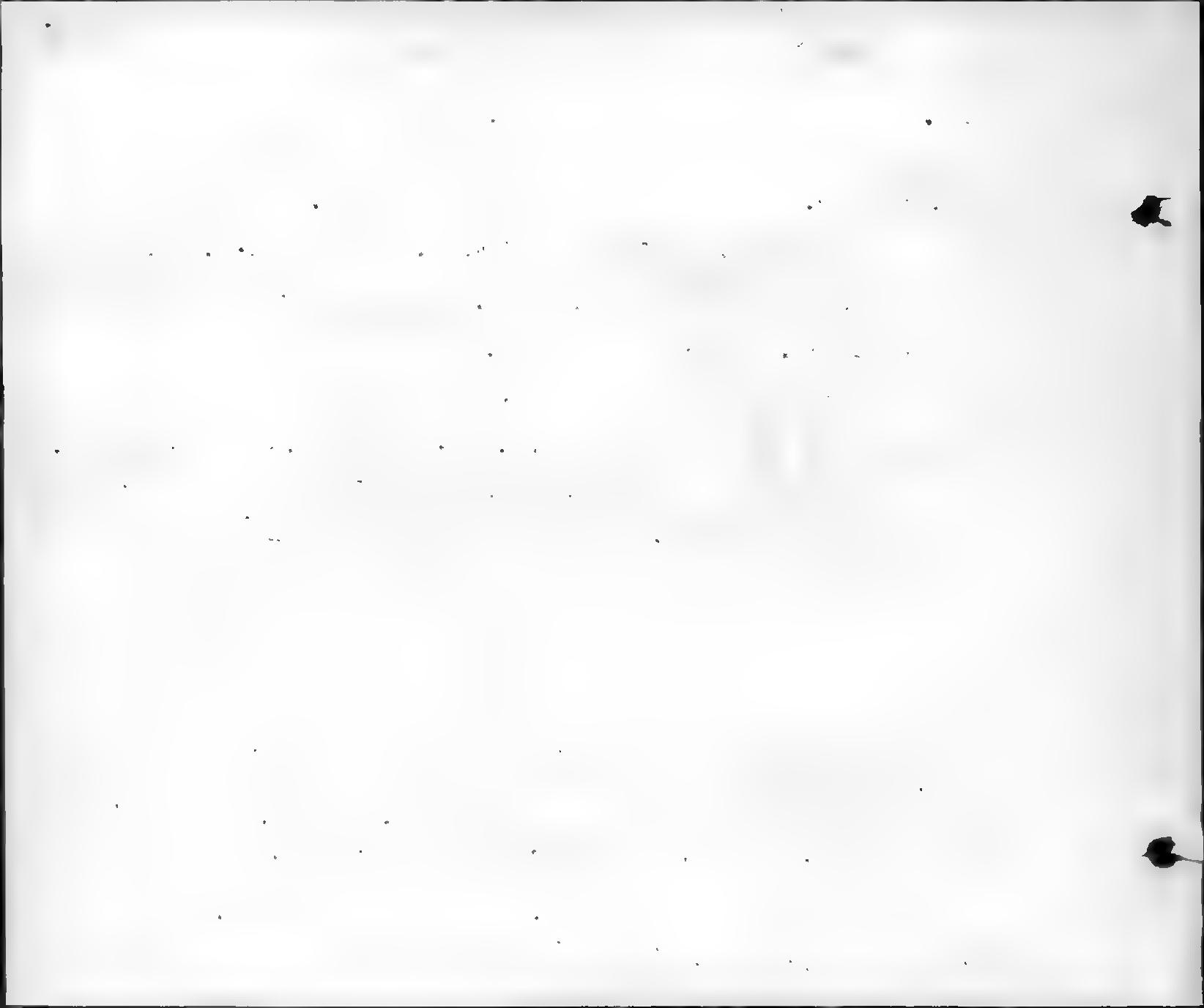
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **10054**

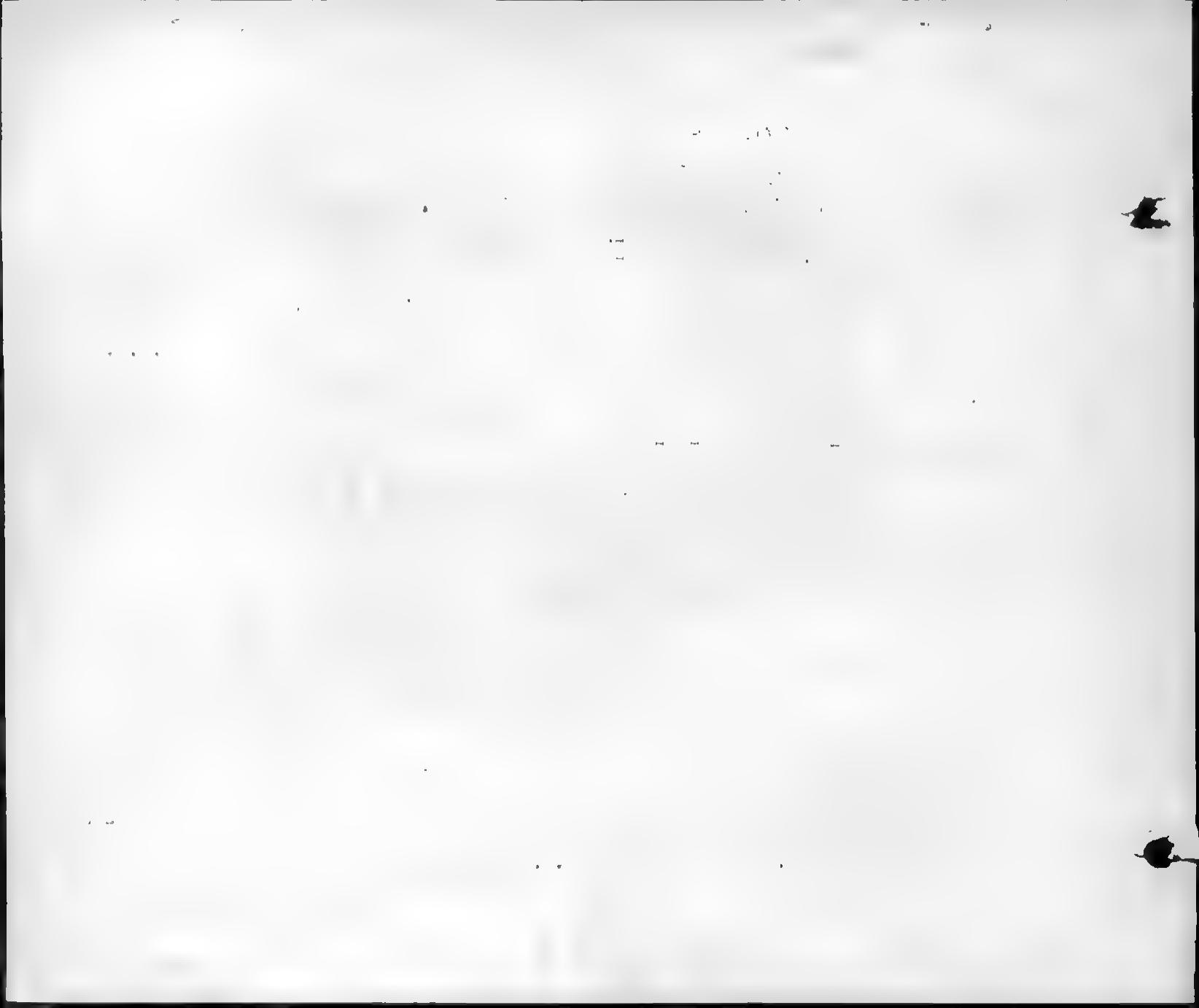
1. PLACE OF DEATH a. COUNTY Baltimore.		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b RURAL and give nearest town Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Sheraton Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 4414 Glen Arm Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BERNARD	Middle EDWARD	Last SUTER, Sr.
4. DATE OF DEATH	Month Sept.	Day 3,	Year 19 60
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1903
9. AGE (In years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer - self emp.	11. KIND OF BUSINESS OR INDUSTRY Grocery	12. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Harry Edward Suter		14. MOTHER'S MAIDEN NAME Ida May Devilbiss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 111-11-1111	INFORMANT Mr. B. Edward Suter, Jr. - 4414 Glenarm Ave.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. L20-1 (b) Arterosclerotic cardiovascular disease 10 mos. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 20, 1960 to Sept 3, 1960 , that I last saw the deceased alive on Aug. 25, 1960 , and that death occurred at 432A M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Marvin H. Davis, Md. 9/6/60	
ACTUAL SIGNATURE Marvin H. Davis		M.D.	
PHYSICIAN'S NAME (Type) Marvin H. Davis, Md., 6512 Liberty Road, Baltimore 7, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/60	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem.	22d. LOCATION (City, town, or county) Woodlawn, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Schaefer & Sons, Inc.		ADDRESS 17 Med	24a. REC'D DATE REGISTRATION DATE SEP 7 '60
			24b. REGISTRAR'S SIGNATURE John J. Schaefer



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										10055			
10083					CERTIFICATE OF DEATH								
1. PLACE OF DEATH o. COUNTY		BALTIMORE			MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		o. STATE MARYLAND			b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FORT HOWARD			c. LENGTH OF STAY IN 16 31 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE			d. STREET ADDRESS 32 NORTH ELLWOOD AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		VETERANS ADMINISTRATION HOSPITAL					e. IS RESIDENCE ON A FARM?					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		STEPHEN Served as: STEPHEN			Middle --- SZCZUBLEWSKI		4. DATE OF DEATH SEPTEMBER 1, 1960		Month			Doy Year	
5. SEX MALE		6. COLOR OR RACE WHITE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-35-1892		9. AGE (In years lost birthday) 67 yrs			10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOX MAKER		10b. KIND OF BUSINESS OR INDUSTRY Copper & Brass Co			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME ANDREW SZCZUBLEWSKI					14. MOTHER'S MAIDEN NAME AGNES KISTOWSKI								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) YES		16. SOCIAL SECURITY NO WW-1			17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY					INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) ARTERIOSCLEROSIS					UNKNOWN						
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
19													
21. I certify that (I) (this hospital) attended the deceased from August 4, 1960, to September 4, 1960, that (we) last saw the deceased alive on September 4, 1960, and that death occurred at 6:00 M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Joseph L. Reeves</i>		M.D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-4-60						
22c. PHYSICIAN'S NAME (Type) JOSEPH L. REEVES		M.D.			22d. ADDRESS YAH BALTIMORE MD FT HOWARD DIVISION								
23a. BURIAL/CREMATION REMOVAL (Specify BURIAL)		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORIUM HOLY ROSARY			23d. LOCATION (City, town, or county) BALTIMORE MARYLAND		(State)				
24. FUNERAL DIRECTOR'S SIGNATURE John M Weber Funeral Home		ADDRESS 401 S Chester St Baltimore 24 Md			25a. REC'D BY REGISTRAR DATE SEP 7 '60		25b. REGISTRAR'S SIGNATURE <i>Clinton S. Trahan</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

100084

CERTIFICATE OF DEATH

Reg. Dist. No.

10056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be rebinned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 61 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 418 S. Rolling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ethel	Middle Louise
		Last Taylor	4. DATE OF DEATH Sept. 12, 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8/22/1891		9. AGE (in years last birthday) 69 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry J. Taylor		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Nellie Taylor 418 S. Rolling Road		Address Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-11, 1960, to 9-12, 1960, that I last saw the deceased alive on 9-12, 1960, and that death occurred at 4 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James E. Howell M.D. ADDRESS (Street, city or town, state) Catonsville		DATE SIGNED 9-13	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Easton's Sons		24a. REC'D BY REGISTRAR SEP 15 '60	
ADDRESS Catonsville, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Thorne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

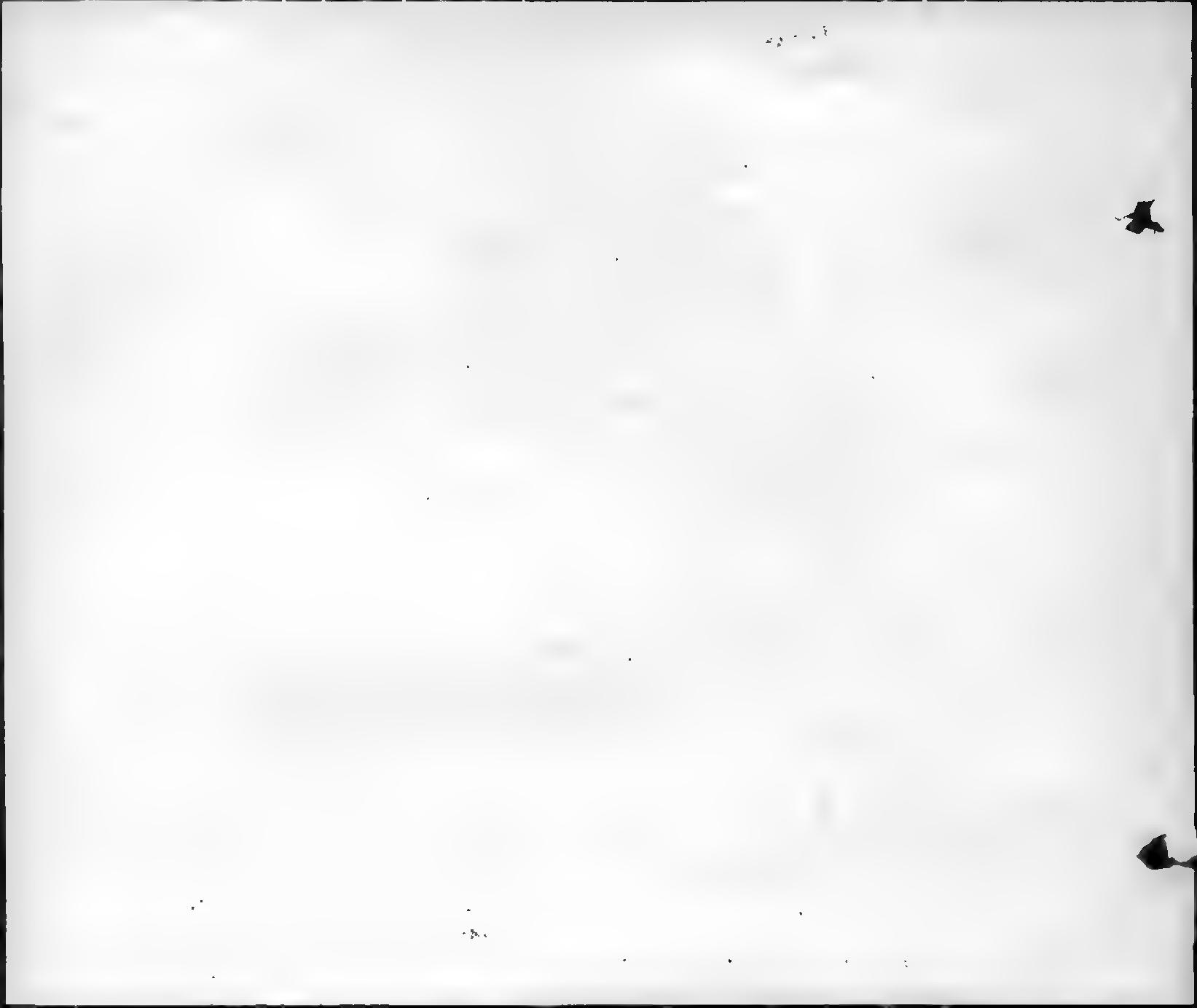
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10057

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) ✓ o. STATE <i>Maryland</i>				b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton, Md.</i>		c. LENGTH OF STAY IN 1b <i>4 yr 1 mo 1 da</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 3751</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>				d. STREET ADDRESS <i>2814 Ganley Drive</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>David</i>		First	Middle	Last	4. DATE OF DEATH <i>9 - 14 - 1960</i>	Month	Day	Year					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-16-51</i>	9. AGE (in years last birthday) <i>9 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Allen Claude Testerman</i>			14. MOTHER'S MAIDEN NAME <i>Alice Mae Ryan</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Allen C Testerman</i>			Address <i>2814 Ganley Drive</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status Epilepticus</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mental Retardation</i> since birth (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>		(County) <i>None</i>		(State) <i>Md.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>8-3-1960</i> to <i>9-14-1960</i> that (I) (we) last saw the deceased alive on <i>9-14-1960</i> , and that death occurred at <i>12 M.</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>H.R. New</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>9-14-60</i>									
22c. PHYSICIAN'S NAME (Type) <i>H.R. New M.D.</i>		22d. ADDRESS <i>Rosewood State Training School, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 19, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Balto Natl.</i>		23d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 19 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10086 CERTIFICATE OF DEATH

10058

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Md.		b. COUNTY		Baltimore	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Pikesville 8		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville 8, Md.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1121 Nelson Rd., Pikesville 8, Md.				Nelson Road							
3 NAME OF DECEASED (Type or print)		First	Middle	Last	4 DATE OF DEATH	Month	Day	Year			
John		James	Thomas Sr.		Sept. 11,			1960			
5. SEX Male		6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug 24, 1906	9 AGE (In years last birthday) 81	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 IF UNDER 24 HRS Hours	13 IF UNDER 24 HRS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY J.W. Marchant		11 BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert Thomas		14. MOTHER'S MAIDEN NAME Margaret McGaugh									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 123-45-6789		INFORMANT Mrs. Mary E. Thomas, Nelson Rd., Pikesville 8		Address 811 N. Main St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MASSIVE MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last		(b) CORONARY OCCLUSION									
(c) CORONARY ATHEROSCLEROSIS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)									
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pikesville		(County)		(State)	
21. I certify that I attended the deceased from JUNE 4, 1960, to SEPT. 11, 1960, that I last saw the deceased alive on SEPT. 11, 1960, and that death occurred at 6:00 A.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) 1331 Reisterstown Road		DATE SIGNED 9/13/60			
ACTUAL SIGNATURE Samuel P. Scalias, M.D.											
PHYSICIAN'S NAME (Type)											
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Pikesville 8, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell, Pikesville 8		ADDRESS				24a. REC'D BY REGISTRAR Date SEP 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10059

10087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with

VR A15 (4)
15M 9/59

1. NAME OF DECEASED (Type or Print)		ARTHUR F. X. J. Thorpe SR			2. DATE OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		Sept. 5, 1960					
Baltimore County							
1253 Dartmouth Rd							
Baltimore, MD							
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution give street address or location)					
1253 Dartmouth Rd							
Baltimore, MD							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Year	If Under 24 Hours	
M	W	Single	Feb 29, 1948	12	Months	Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerk		Clerk		Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
ARTHUR F. X. J. Thorpe SR.		Hilda Lyons					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				mother.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		<p>(A) Prostate 1253 Dartmouth Rd Due to Prost. ag</p> <p>(B) metastatic malignancy Due to (undifferentiated & well differentiated Sarcoma)</p> <p>(C)</p>					
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT							
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from Sept. 5 1960 that (I) (we) last saw the deceased alive on Sept. 3 1960 and that in (my) (our) opinion death occurred at 11:50 AM, from the causes and on the date stated above.							
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED			
ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		M.D. 4726 Old Court Rd		Sept 5, 1960			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIAL		24D. LOCATION	
BURIAL		9-7-60		Dulaney Valley Memorial		Baltimore County, Md	
DEATH DATE		25A. NAME OF HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 7 1960		Health Dept.		Arthur J. Thorpe		John Cook-Towson, Inc., 1050 York Road	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10088

CERTIFICATE OF DEATH

Reg. Dist. No.

10060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1008 J Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
f. STREET ADDRESS 1008 J Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Caroline	Middle (Tilghman)	Last Tillman
4. DATE OF DEATH	Month September	Day 11	Year 1960
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1888
9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wadesboro, N. C.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME George Lomax		14. MOTHER'S MAIDEN NAME Elizabeth Benton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Eli Tillman - 1008 J St., Sparrows Point, Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c)			
<i>Virus pneumonia</i> <i>Left hemiplegia</i> <i>Aterio-sclerosis + hypertension</i>			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-----</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 14 p. m. 14		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from August 25/60 to Sept 11th 60 , that I last saw the deceased alive on September 11th 60 , and that death occurred at 12:30A from the causes and on the date above ACTUAL SIGNATURE <i>J. H. Thomas</i> M.D. 107th Maine, Balto 2270 ADDRESS (Street, city or town, state) DATE SIGNED 			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-60	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		24a. REC'D BY REGISTRAR DATE SEP 15 '60	
ADDRESS 802 Madison Ave.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fine</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10061

10089

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		d. STREET ADDRESS <i>1 Hillview Dr.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Mary's Nook Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <i>Sept 3 1960</i>		Month Day Year					
3. NAME OF DECEASED (Type or print)	First <i>Anna E.</i>	Middle <i>Tracey</i>	Last	5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/21/90</i>	9. AGE (In years last birthday) <i>70 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homesteader at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>nd</i>		11. BIRTHPLACE (State or foreign country) <i>nd</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Jacob Haemel</i>		14. MOTHER'S MAIDEN NAME <i>Catherine E. Rosbach</i>		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i></i>		17. INFORMANT <i>Walter K. Tracey</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>myocardial insufficiency</i>		DUE TO <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18 MO					
Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Bronchogenic carcinoma</i>									
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>hypertrophic arthritis</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 17 1939</i> to <i>Sept 3 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 3 1960</i> , and that death occurred at <i>9:29 AM</i> , from the causes and on the date stated above		22a. SIGNATURE <i>George A. Knipp</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>Sept 3 1960</i>					
22c. PHYSICIAN'S NAME (Type) <i>George A. Knipp M.D.</i>		22d. ADDRESS <i>4116 Edmondson Ave Baltimore Md</i>									
23a. BURIAL CREMATION, REMOVAL, (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/6/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>		23d. LOCATED ON (City, town, or county) <i>Baltimore Co Md</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Knapp Jr.</i>		ADDRESS <i>28</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 6 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10062

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 22 New Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle D.	Last TRUMP	4. DATE OF DEATH September 28 1960	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1939	9. AGE (in years last birthday) 21 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. JS/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier- Airman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force		11. BIRTHPLACE (State or foreign country) Manchester, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles R.				14. MOTHER'S MAIDEN NAME Ethel Masemore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 3/6/57; 3/30/59 214-36-9191		17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH 12 HOURS							
DUE TO 204 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE LYMPHOCYTIC LEUKEMIA 20 MONTHS							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12, 1960 to September 28, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 28 1960 , and that death occurred at A. M. from the causes and on the date stated above							
22a. SIGNATURE <i>Frederick S. Donaldson</i>				M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTO. 18, MD FORT HOWARD MARX DIVISION			
23a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		23b. DATE THEREOF 10-1-1960		23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		23d. LOCATION (City, town, or county) Manchester, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Edw. C. Tipton, Hampstead, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 '60	25b. REGISTRAR'S SIGNATURE J. L. Kline



10091

CERTIFICATE OF DEATH

Reg. Dist. No.

10064

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4049 Cedardale Read		d. STREET ADDRESS 4049 Cedardale Read		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward Cordell Tyson		First	Middle	Last	4. DATE OF DEATH 9 12 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1960	9. AGE (In years last birthday) yrs. 6	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 16	Hours 0	Min. 0
10a. J.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Prevident Hosp		12. CITIZEN OF WHAT COUNTRY? Baltimore, Maryland		
13. FATHER'S NAME Edward Tyson		14. MOTHER'S MAIDEN NAME Gloria Inez Jenkins		INFORMANT Rosewood Records		Address Owings Mills, Md.		
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Quadrant 752 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hydrocephalus non communicans Bertk (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 57 days		
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) Owings Mills (State) Md.		
21. I certify that I attended the deceased from 8/22 - 1960 to 9/2/1960 that I last saw the deceased alive on 9/2/1960 , and that death occurred at 10:55 AM from the causes and on the date stated above. ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills, Md. 21046		DATE SIGNED 9/2/1960				
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/60		22c. NAME OF CEMETERY OR CREMATORIUM Clarke Memorial Park		22d. LOCATION (City, town, or county) Marietta, Maryland (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lynch - 2463 Grand St. Atre		ADDRESS 1010 W. 24th Street		24a. REC'D BY REGISTRAR DAT SEP 13 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hunt		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10092 10065

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Baltimore</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	c. LENGTH OF STAY IN lb <i>57</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	d. STREET ADDRESS <i>2120 Frederick Rd.</i>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2120 Frederick Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <i>J. FREDERICK VOGT</i>	First	Middle	Last	4. DATE OF DEATH <i>Sept 10 1960</i>	Month	Day	Year						
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 2, 1893</i>	9. AGE (In years last birthday) yrs. <i>67</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	IF UNDER 24 MINS Mins <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sold & See Books - Am. Can.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>J. BIRTHPLACE (State or foreign country)</i> <i>Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>C.S.A.</i>							
13. FATHER'S NAME <i>John J. Vogt</i>			14. MOTHER'S MAIDEN NAME <i>Mary Margaret Weiland</i>			Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] <i>No</i>			16. SOCIAL SECURITY NO <i>21209586</i>			17. INFORMANT <i>Leon E. Vogt</i>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>			DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Coronary Thrombosis arterio Sclerosis (General) 10 yrs</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, if item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore Co.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>8-1 1960</i> to <i>9-10 1960</i> that (I) (we) last saw the deceased alive on <i>9-10 1960</i> and that death occurred at <i>10 AM</i> , from the causes and on the date stated above									22b. DATE SIGNED <i>9-12</i>				
22a. PHYSICIAN'S NAME (Type) <i>James E. Howell</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. ADDRESS <i>Catonsville</i>								
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/13/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Grind Ridge</i>		23d. LOCATION (City, town or county) <i>Baltimore Co. Md.</i>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Howell</i>		ADDRESS <i>28</i>			25a. REC'D BY REGISTRAR DATE <i>SEP 14 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howell</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10066

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 262 Patapsco Avenue		d. STREET ADDRESS 262 Patapsco Avenue e. U.S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		First LEE	Middle WAMSLEY
4. DATE OF DEATH		Month September	Day 6th, 1960 Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1881
9. AGE (In years last birthday) 79 yrs.		(IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Paint	
10c. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Wamsley		14. MOTHER'S MAIDEN NAME Anne Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 233-18-8211 May P. Wamsley same as #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic heart dis.</i> DUE TO (c) <i>Generalized atherosclerosis</i>		10 yrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 9/7/60	
ACTUAL SIGNATURE <i>Jack Collins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Burial		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9/9/60		22c. NAME OF CEMETERY OR CREMATORIAL Boring Cemetery	
22d. LOCATION (City, town, or county) (State) Davisson Run, West Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.	
ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 8 '60	24b. REGISTRAR'S SIGNATURE <i>Clara S. Trahan</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10093

CERTIFICATE OF DEATH

Reg. Dist. No.

10067

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS →		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE		First	Middle	Last	4 DATE OF DEATH Sept. 15, 1960
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1871		9 AGE (in years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Theodore Hessinger		14 MOTHER'S MAIDEN NAME Caroline Engelkirk		12. CITIZEN OF WHAT COUNTRY? Sarasota, Fla.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		INFORMANT Mr. Leroy Fenne - 2111 McClellan Pkwy.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Cerebral hemorrhage Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH hours week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Asthma				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Ernest C Brown M.D. 1101 N. Calvert St	
ACTUAL SIGNATURE Ernest C Brown				DATE SIGNED 9/16/60	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60		22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Mem. Pk.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Sickner & Sons - Baltz		ADDRESS DATE		24a. REC'D. BY REG. STAR Sept. 19 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Mann	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10094

10068

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.			c. LENGTH OF STAY IN 1b 8 Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First SAMUEL	Middle E.	Last WATERS	4. DATE OF DEATH Month September			
S SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 23, 1895	9. AGE (In years from birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. Year 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jim Waters			14. MOTHER'S MAIDEN NAME Annie Hawkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <small>(If no, or unknown)</small>		16. SOCIAL SECURITY NO. 213-10-3037		17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GLOMERULONEPHRITIS DUE TO (c) ANASARCA AND NEPHROTIC SYNDROME INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN 1 MONTH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 20 1960 to September 28, 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 28 1960, and that death occurred at P.M., from the causes and on the date stated above								
22a. SIGNATURE G. M. Snyder, M.D.				22b. DATE SIGNED 9/29/60				
22c. PHYSICIAN'S NAME (Type)		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-60		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d. LOCATION (City, town or county) Baltimore (State) Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Adolph J. Collick				ADDRESS 1412 E. Preston St., Balto. Md.		25a. REC'D BY REGISTRAR OCT 4 '60	25b. REGISTRAR'S SIGNATURE Collected & Kept	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10069

1. PLACE OF DEATH a. COUNTY	Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE	Maryland	b. COUNTY	Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rosedale	c. LENGTH OF STAY IN lb	X	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	7222 Hilltop Avenue	d. STREET ADDRESS	7222 Hilltop Avenue	e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED
(Type or print) **LILLIAN AUGUSTA WEAVER**

First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Female	white	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	Dec. 6, 1880	SEPT	20	1960

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS	13. MIN
Female	white	WIDOWED <input checked="" type="checkbox"/>	Dec. 6, 1880	79 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Charles M. Scott	Rose M. Preston		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs. Mildred M. Appel	same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	SUDDEN
422.1	Cerebro-Vascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO
	(b) Arteriosclerotic cardiovascular Disease
	DUE TO
	(c)

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from Sept. 1, 1960, to Sept. 20, 1960, that I last saw the deceased alive on Sept. 20, 1960, and that death occurred at 11:30 PM, from the causes and on the date stated above

ACTUAL
TIME: G. M. Baumgardner M.D. ADDRESS (Street, city or town, state) Baltimore, Md DATE SIGNED 9/20/60
PHYSICIAN'S NAME (Type) G. M. Baumgardner

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
Burial	9/24/60	Holy Redeemer Cem.	Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Leonard J. Ruck	5305 Harford Road #14	DATE <u>SEP 22 '60</u>	<u>John G. Kline</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

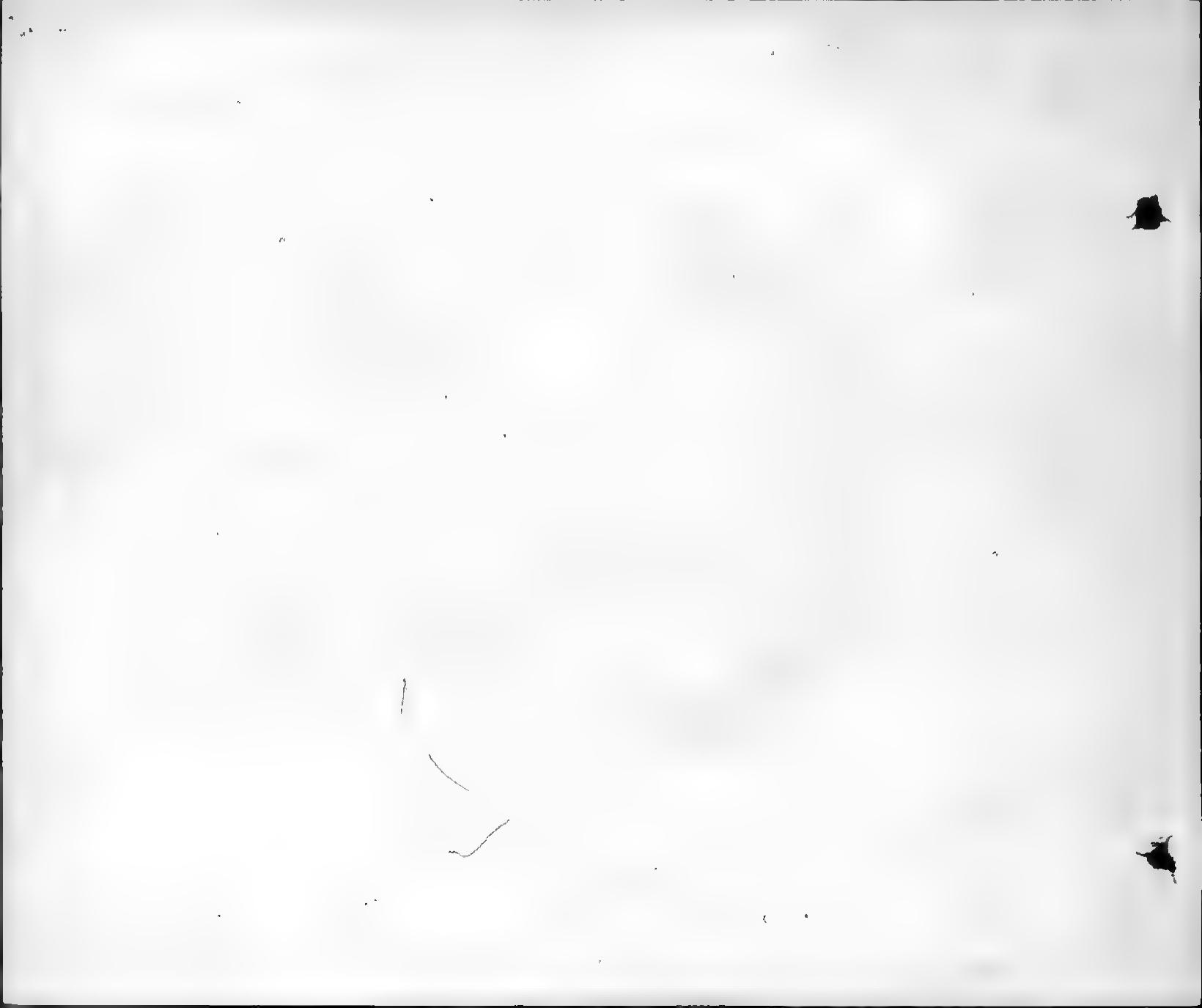
10096

CERTIFICATE OF DEATH

Reg. Dist. No.

10070

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		Rosedale		c. LENGTH OF STAY IN lb		3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		7604 Philadelphia Rd.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
5. SEX		Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		watchman		10b. KIND OF BUSINESS OR INDUSTRY		July 2, 1882		78 yrs	Months	Days	Hours
13. FATHER'S NAME		Charles Weisenian		11. BIRTHPLACE (State or foreign country)		East Brady, Pennsylvania		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown)		No		16. SOCIAL SECURITY NO.		INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Arteriosclerotic Heart Disease		6 Mos.			
		(c)									
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 1960, to Sept 20, 1960, that I last saw the deceased alive on Sept 20, 1960, and that death occurred at 11 th AM, from the causes and on the date stated above.								ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		Ernest R. Davis, M.D.		5317 Decatur Rd		Baltimore 6, Md		DATE SIGNED 9/27/60			
PHYSICIAN'S NAME (Type)		Ernest P. Davis									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		Sept. 23, 1960		West End Cemetery		Wytheville, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Ernest P. Davis					
D. Barnard Jr.		Wytheville, Virginia		Sep 23 1960							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												10071					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY		Baltimore				MARYLAND				2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville				c. LENGTH OF STAY IN 1b				a. STATE Md.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Caton Ridge Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY Anne Ar.							
e. STREET ADDRESS		Formerly of 406 Normandy Av								d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1888		9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Hours		12. IF UNDER 24 HRS Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Mail Carrier		H. S. Gash		W. Va.													
13. FATHER'S NAME Wm. Wells		14. MOTHER'S MAIDEN NAME Lucretia															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address Zone 7											
						Raymond Wells, 5436 Montebello Ave											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.																	
DUE TO <i>Congestive failure</i>																	
(b) DUE TO <i>Arteriosclerotic cardio vascular d.</i>																	
(c) DUE TO <i>10 yrs</i>																	
INTERVAL BETWEEN ONSET AND DEATH 2-5.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																	
<i>chronic bronchial asthma</i>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
19																	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1957, to Sept. 8, 1960, that (I) (we) last saw the deceased alive on Sept. 8, 1960, and that death occurred at 1011 Frederick Road, Cat #8, Md.																	
22a. SIGNATURE <i>James E. Rowe</i>		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>9/8/60</i>							
22c. PHYSICIAN'S NAME (Type) James E. Rowe, M.D.		22d. ADDRESS 1011 Frederick Road Cat #8, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify Removal)		23b. DATE THEREOF Sept. 10/60		23c. NAME OF CEMETERY OR CREMATORIAL Barrand Ok.		23d. LOCATION (City, town, or county) Woodlawn, Md.				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witzie Y.N.</i>		ADDRESS 101 Edmonson Av		25a. REC'D BY REGISTRAR DATE SEP 13 '60				25b. REGISTRAR'S SIGNATURE <i>J. E. Rowe</i>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10098

CERTIFICATE OF DEATH

10072

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN TB

5yr 3mth 11dys

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

SPRING GROVE STATE HOSPITAL

3. NAME OF
DECEASED
(Type or print)First
CharlesMiddle
HenryLast
Winfield4. DATE
OF
DEATH

September

Month
Day
Year
15th, 1960

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

October 17, 1875

9. AGE (In years
last birthday)

81 yrs

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS

Hours
Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry Winfield

14. MOTHER'S MAIDEN NAME

Lucy Ann Head

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

223-14-6957

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

Ischaemic heart failure

INTERVAL BETWEEN
ONSET AND DEATH

one day

DUE TO

(b)

DUE TO

(c)

Bilateral Pneumonia

MEDICAL CERTIFICATE ON

19. WAS AUTOPSY PERFORMED?
YES NO

Generalized Arteriosclerosis — Debilitus ulcerations

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1960, to Sept. 15, 1960, that (I) (we) last saw the deceased alive on Sept. 15, 1960, and that death occurred at 8:30 PM, from the causes and on the date stated above

22a. SIGNATURE

José R. Arizaga,
JOSE R. ARIZAGA, M.D.

M.D. ATTENDING PHYS

MED. DIRECTOR STAFF PHYS 22b. DATE
5/26/6022c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
17th Sept. 1960 Ephesus Church Cemetery

23d. LOCATION (City, town, or county)

(State)

Foneswood, Virginia

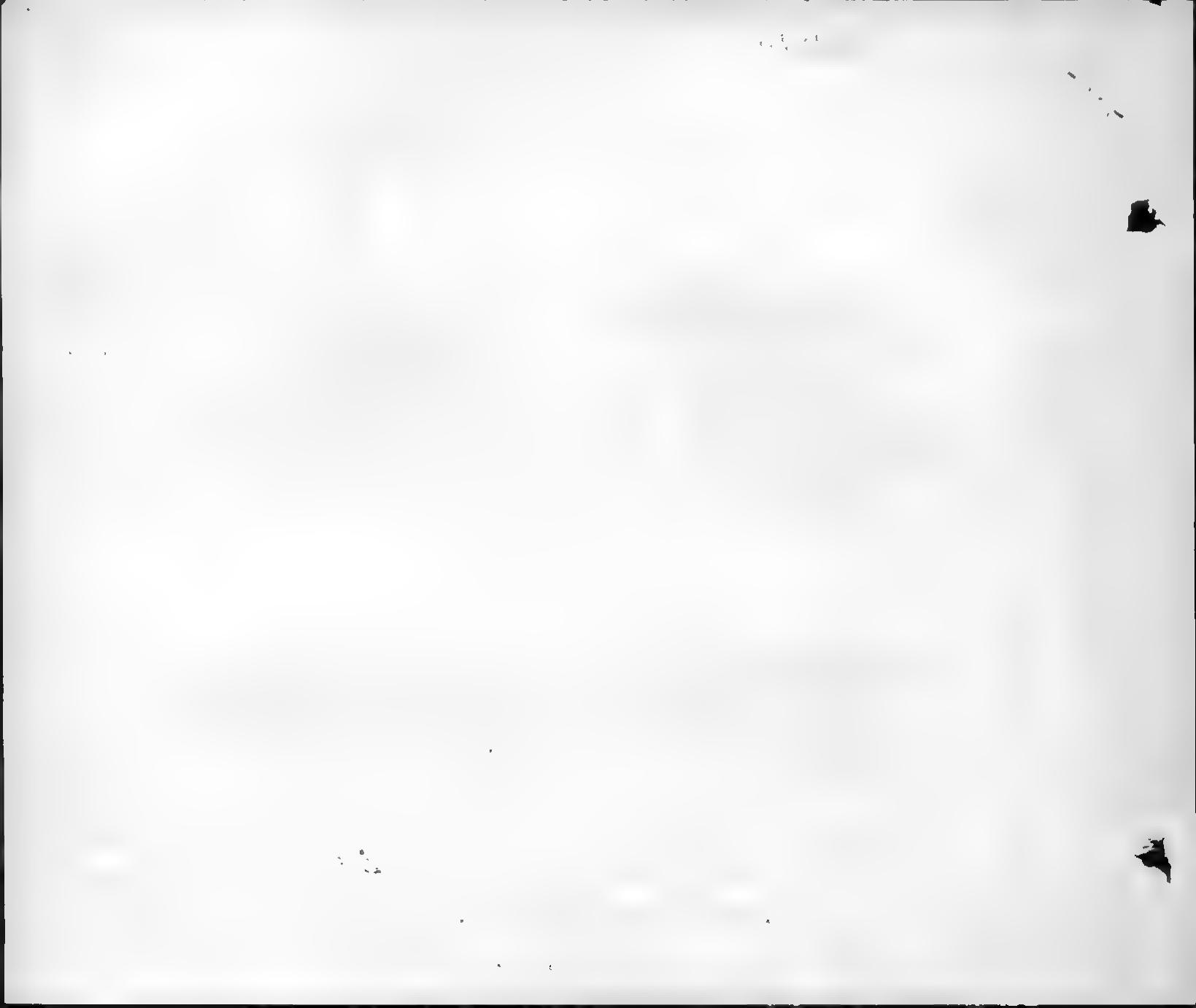
24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Richard J. Langford

Glen Burnie, Md.

25a. REC'D BY REGISTRAR
DATE SEP 19 196025b. REGISTRAR'S SIGNATURE
Orion S. Knott



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10073

10699

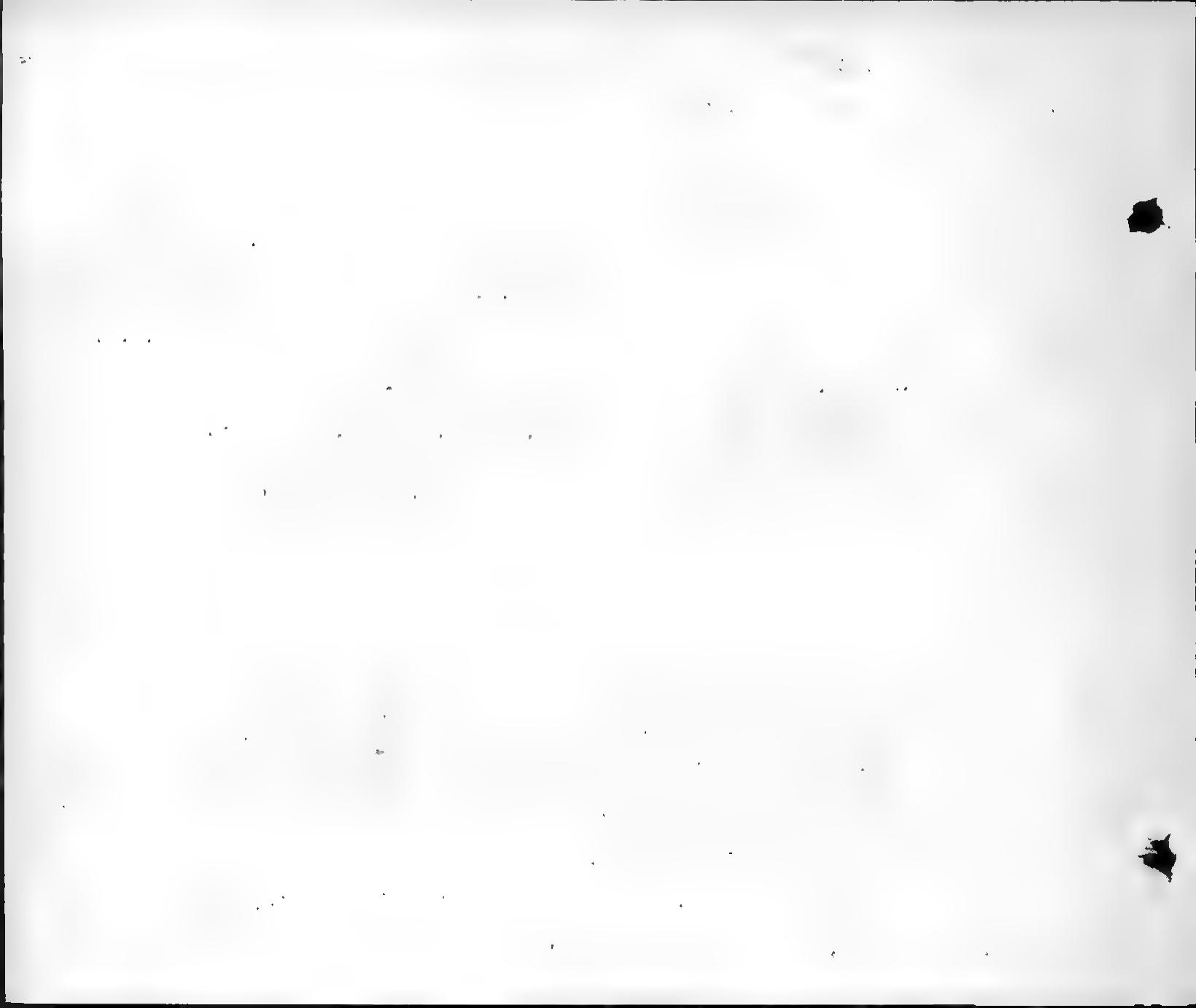
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Monkton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton, Md		c. LENGTH OF STAY IN 1b X MONKTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Big Falls Road		e. STREET ADDRESS Big Falls Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First G	Last Wisner
4. DATE OF DEATH SEPT. 16 1960		Month	Day Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 8, 1879		9. AGE (In years at birthday) 80 yrs.	10. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Butler, Md	
11. BIRTHPLACE (State or foreign country) Butler, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis T. Wisner		14. MOTHER'S MAIDEN NAME Sarah D. Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Mary L. Walters,		Address Monkton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 to SEPT. 16 1960 that I last saw the deceased alive on 9/16/60 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. France		ADDRESS (Street, city or town, state) Parkton, Md	
PHYSICIAN'S NAME (Type) A. M. FRANCE		DATE SIGNED 9/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-19-60	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion United Brethren		22d. LOCATION (City, town, or county) Black Rock Road Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road Towson		ADDRESS 4	24a. REC'D BY REGISTRAR DATE SEP 20 '60
		24b. REGISTRAR'S SIGNATURE Charles S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

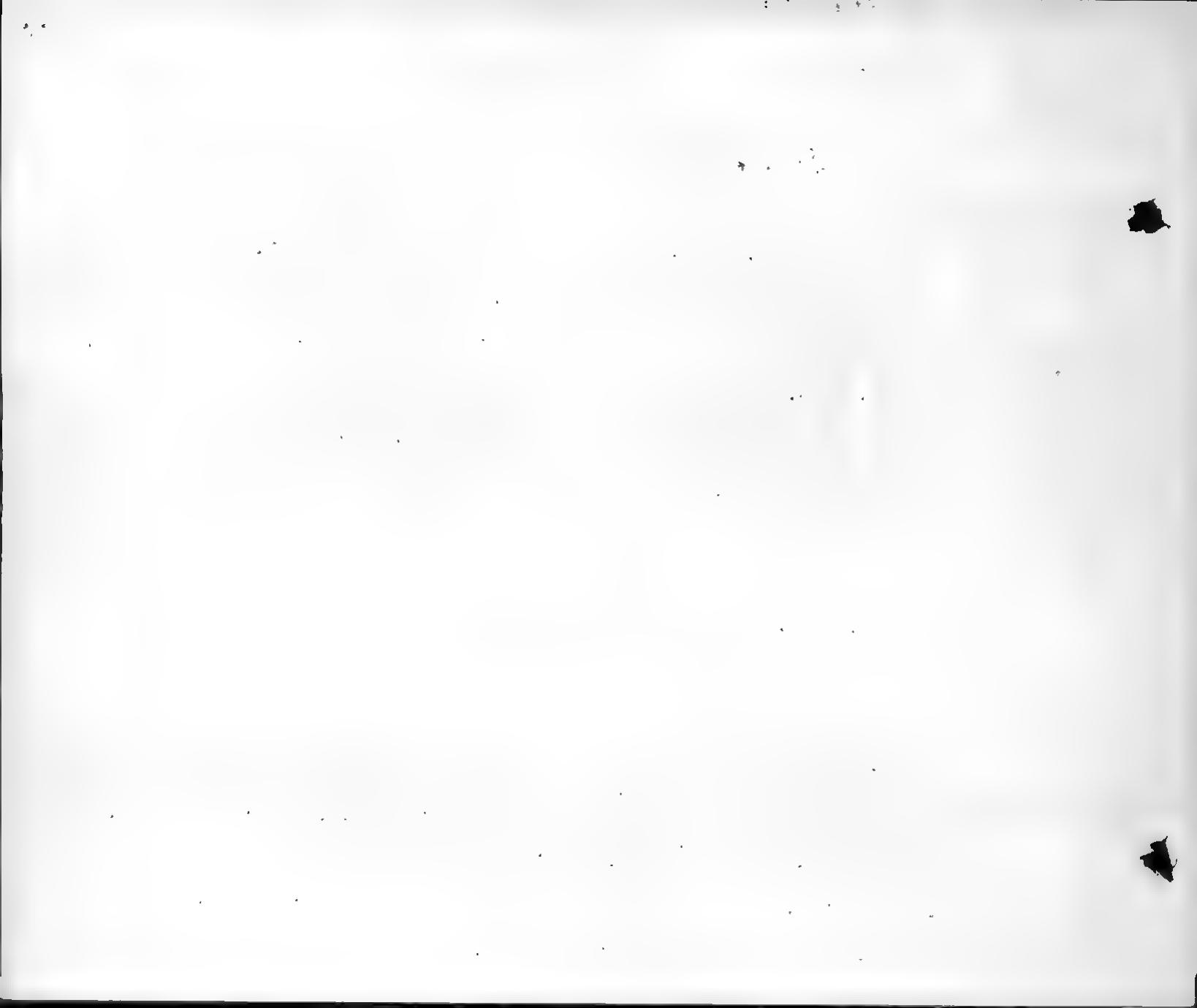
Reg. Dist. No.

10074

1 PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX BALTIMORE 21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 640 Rockaway Beech		d. STREET ADDRESS 640 Rockaway Beech		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George A. Wittman	Middle	Last	4. DATE OF DEATH	Month Sept.	Day 15, 1960	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1885	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Doys 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired Six Years		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George A. Wittman		14. MOTHER'S MAIDEN NAME Louise Wittman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		INFORMANT 640 Rockaway Beech Avenue Mrs Minnie J. Wittman			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral arterosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Baltimore
21. I certify that I attended the deceased from Sept. 14, 1960 at 1959 , 1960 that I last saw the deceased alive on Sept. 14, 1960 and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE ROBERT J. LYDEN		ADDRESS (Street, city or town, state) 815 Eastern Ave					
PHYSICIAN'S NAME (Type) ROBERT J. LYDEN, MD.		DATE SIGNED 9/17/60					
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/60		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE SEP 20 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kress	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9950

CERTIFICATE OF DEATH

Reg. Dist. No.

10075

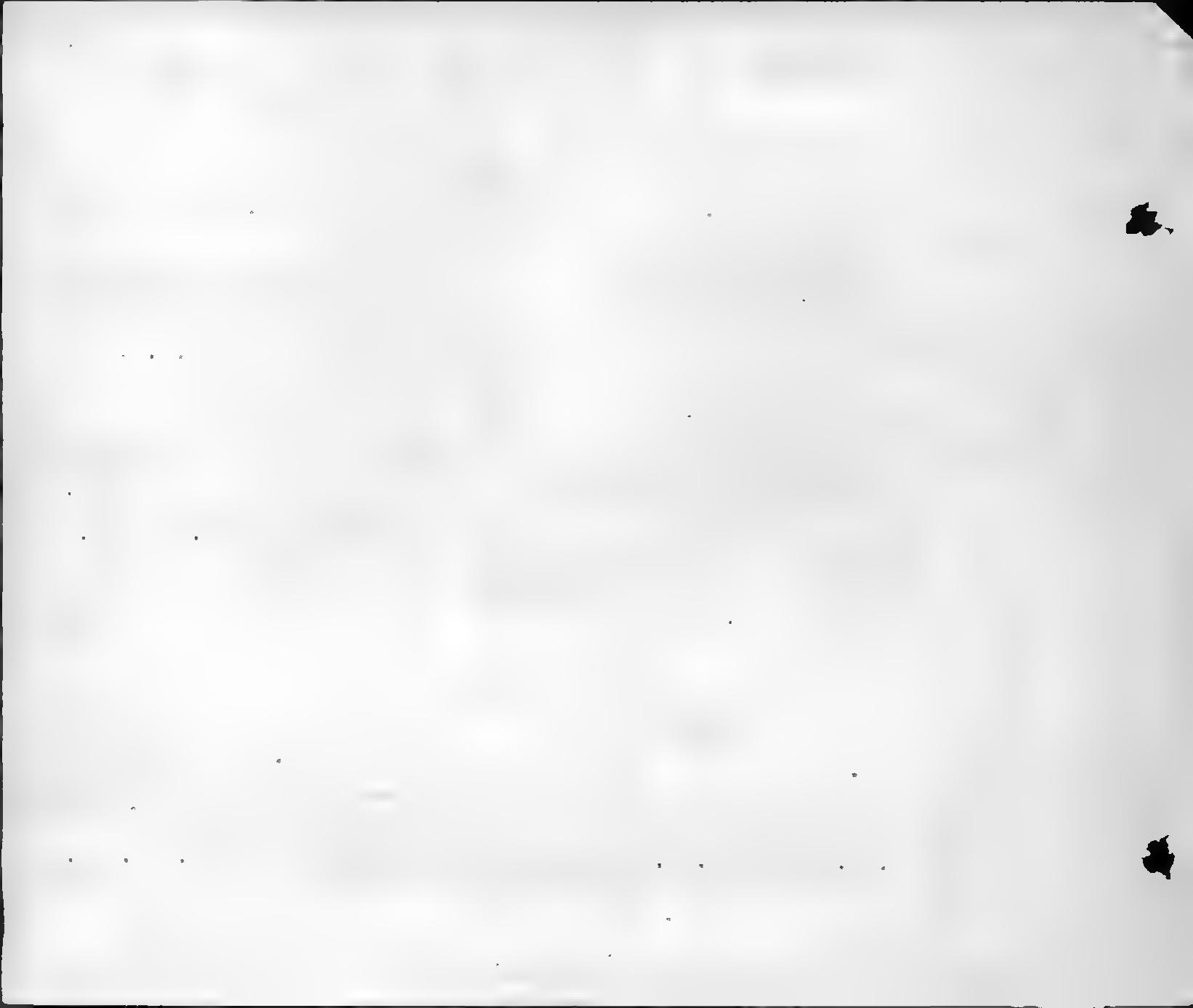
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN lb 29 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2025 Northeast Ave.		d. STREET ADDRESS 2025 Northeast Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida Miles Woodford		First	Middle	Last	4 DATE OF DEATH Sept. 11,	Month	Doy	Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1868		9. AGE (in years last birthday) 92	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mason Miles		14. MOTHER'S MAIDEN NAME Adele		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Lucille Woodford 2025 Northeast Ave.			
17. INFORMANT Pulmonary Embolus		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO Chronic venous congestion of lower extrem.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 min.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) March 1955, 19. 5 to 11 of Sept 1960					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2329 Harlem Avenue Balto. 16. Md.		20f. (City or town) Baltimore		(County) 0	(State) Md.
21. I certify that I attended the deceased from alive on 11 Sept. 60		22. DATE THEREOF 9/15/60		23. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cemetery		24. LOCATION (City, town, or county) Baltimore Md.			
ACTUAL SIGNATURE <i>E. C. Walden M. D.</i>		M.D.		ADDRESS Herbert E. Nutter- 3035 W. North Ave.		REC'D BY REGISTRAR SEP 19 '60		REGISTRAR'S SIGNATURE <i>Arthur S. Hansen</i>	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial									
26. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

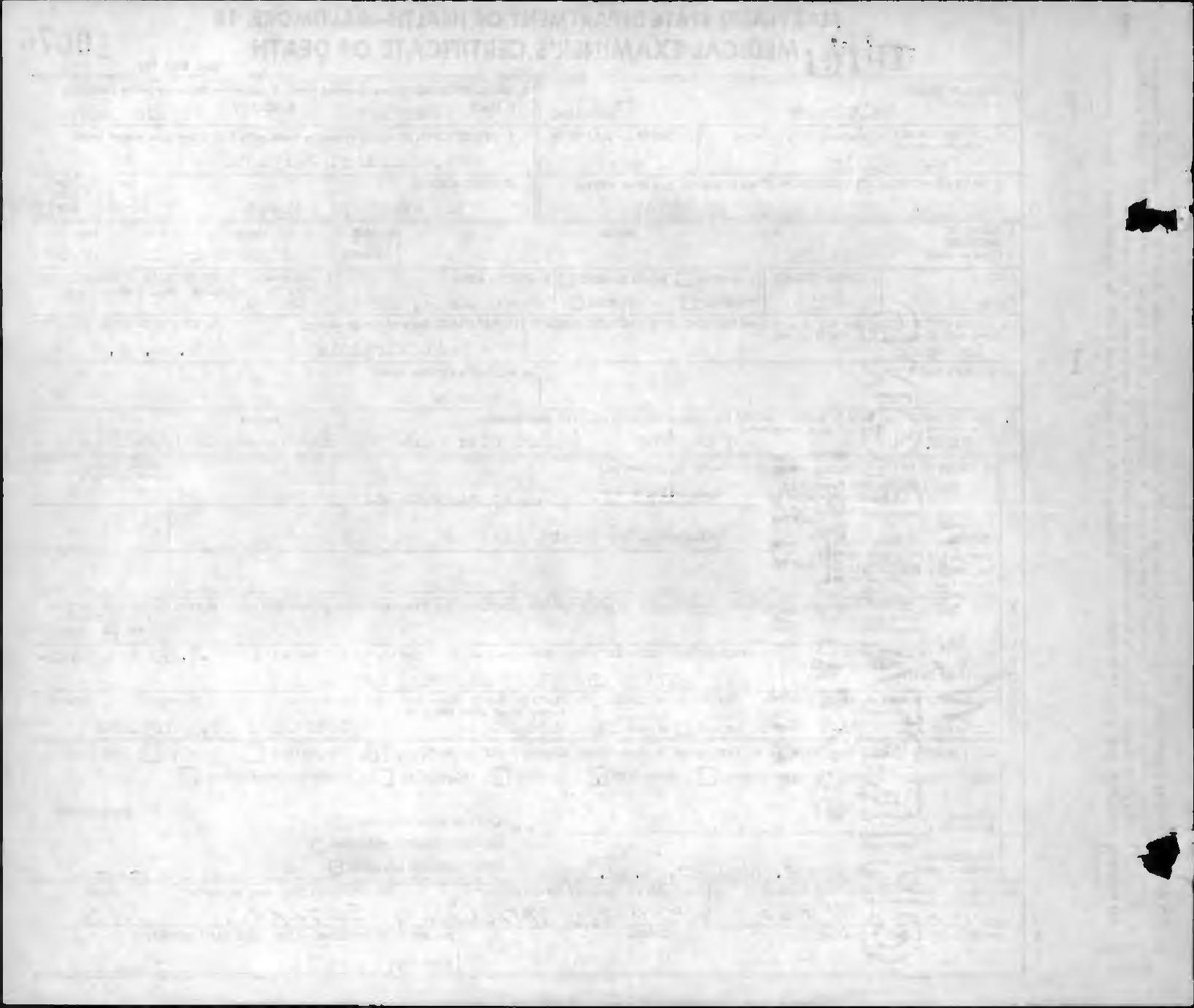
10076

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12 days		d. STATE Maryland		e. COUNTY Prince George			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3204 Shepherd Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stella		First Wright	Middle Wright	Last Wright	4. DATE OF DEATH September 10 1960	Month September	Day 10	Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1895	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknonw							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage; accidental DUE TO (b) Congestive heart failure DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
9-03-7									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 9-7-60 the patient fell to the floor striking her head									
20c. TIME OF INJURY Hour 1:00		Month, Day, Year 9-7 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville	(County) 28, Maryland	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>George M. Kieffer</i>		DATE SIGNED 9-12-60							
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/14/60		22c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NATL. Cem.		22d. LOCATION (City, town, or county) SUITLAND, Mo.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co</i>		ADDRESS Glendale, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE <i>R. L. - 8 Trans</i>			

TO DR MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute in certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILDCAR EXAMINEE'S STATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10102

CERTIFICATE OF DEATH

10077

Item 7 filing 6272 206 (9) et

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTO.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		d. STREET ADDRESS 506 EASTERN BLVD. (21)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 EASTERN BLVD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CAROLINE		First C	Middle WUNDER	Last	4. DATE OF DEATH SEPT. 27 1960	Month SEPT.	Day 27	Year 1960		
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MAY 13-1911	9. AGE (In years lost birthday) 49 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JULIUS W HEFNER		14. MOTHER'S MAIDEN NAME LULA RHODE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT PAUL G WUNDER SR. (SAME AS ABOVE)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinomatosis - Lung (c) DUE TO Carcinoma Breast INTERVAL BETWEEN ONSET AND DEATH 12 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 yrs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Early 1960		(County) 9-27		(State) 1960
21. I certify that (I) (this hospital) attended the deceased from Early 1960 to 9-27 1960 , that (I) (we) last saw the deceased alive on 9-27 1960 , and that death occurred on 9-27 1960 M, from the causes and on the date stated above.										22b. DATE SIGNED 9-29-60
22a. SIGNATURE John E. Gessner		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 701 EASTERN Avenue. (21)						
22c. PHYSICIAN'S NAME (Type) JOHN E. GESSNER										
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 9-30-60		23c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH		23d. LOCATION (City, town, or county) BALTO. MD.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly 418 Eastern Blvd.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 30 1960		25b. REGISTRAR'S SIGNATURE John S. Kuhn				

